Maternal and Child Health Services
Title V Block Grant

State Narrative for New Mexico

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The central office of the New Mexico Title V MCH Program maintains a reference copy on file in the State MCH program's central office and will be made available upon request. If you would like to request copies, please call the Family Health Bureau Chief at 505-476-8901

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Title V Block Grant is available to the public for review at each of the four regional offices of the Public Health Division located in Santa Fe, Albuquerque, Las Cruces and Roswell, as well as the Title V State Office in Santa Fe. A bound copy of the report is placed at in the State Library each year. It is also available on the Department of Health (DOH) website at: http://www.health.state.nm.us/TitleV/ and there is a link to a public input page where comments are emailed to the Title V address: NM.TitleV@state.nm.us. The public may also send hard-copy comments and inquiries to the physical address for the Title V office at: 2040 S. Pacheco, Santa Fe, NM, 87505. Comments are accepted year-round.

The Block Grant Application is distributed to Public Health Division local health offices as a resource for their use in planning efforts for local areas. The performance measures are aligned with the DOH Strategic Plan. The reports to the legislature and its interim committees are based on the information compiled in the grant proposal.

For the 2010 Needs Assessment, the MCH Epidemiology program developed an online survey of Maternal and Child Health priorities. Respondents were asked to rank order 25 MCH priorities according to which they felt were most pressing in their communities. The survey was promoted in several newspapers and on local radio stations around the state. Over 1,000 New Mexicans responded, and over 200 respondents also utilized the comment box at the end of the survey. The results were published on the DOH website and in the Needs Assessment report.

The Maternal and Child Health programs of the Family Health Bureau solicit and receive public input on an ongoing basis as a regular part of their meetings with stakeholders and community partners. The following is a list of organizations and meetings that that include participation from the public:

ECAN (Early Childhood Action Network) Steering Committee (monthly meetings)
Multi-Agency Team Meeting (Young Child Wellness Council) Local & State Level (monthly meetings)

FLAN (Family Leadership Action Network) Planning Council and Annual Meeting
Certified Nurse Midwives Advisory Board (quarterly meetings)
Licensed Midwives Advisory Board (quarterly meetings)
Santa Fe County Home Visiting Collaborative (quarterly meetings)
Home Visiting Task Force (State level) (quarterly meetings)
EPSDT (Early Periodic Screening Diagnostics and Treatment) Meetings (quarterly meeting)
DSI (Developmental Screening Initiative) New Mexico Stakeholder's Update Meeting
Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) (monthly conference call)
Turn the Curve Planning Meetings for ECCS (Early Childhood Comprehensive Systems) Grant and Annual Meeting
House Joint Memorial 60 Task Force Meetings (monthly meetings)
Title V MCH Block Grant Needs Assessment Regional Meetings
Families FIRST Bi-annual Meeting
Public Health Division Prenatal Care Planning Meetings and Annual Meeting
Project LAUNCH Grantee Meetings (twice yearly)
ECCS Grantee Meeting (yearly)
Maternal Depression Work Group (monthly meetings)
Obstetric Liability Insurance Meetings (as needed)
Healthy Weight Council Meetings (3 times per year)
Santa Fe County Maternal Child Health Council (monthly meetings)
Fatherhood Forum: Whitehouse Faith-Based Initiative (weekly meeting)

Children's Medical Services (CMS) continuously receives public input from its stakeholders and community partners. The MCH Collaborative meets monthly and includes CMS, Family Voices, Parents Reaching Out, and EPICS. The advisory councils for the Genetic Screening program, the Newborn Hearing Screening program and for the CYSHCN program meet regularly to ensure continuing efficacy of CMS programs. These advisory councils include representation from various stakeholders including professionals, families, and other agencies. The CMS Social Workers in the field also participate on community councils and receive input from the public on various local maternal and child health issues.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Needs Assessment Summary

The priorities identified in the 2010 Needs Assessment are similar to those identified in 2005. A table comparing the 2005 and 2010 priorities can be found in Appendix 9. Changes were made primarily in order to create priorities that adhered to the S.M.A.R.T. (Specific, Measureable, Attainable, Realistic and Timely) criteria. The 2010 priorities are:

1. Increase accessibility to care for pregnant women and mothers that provides care before, during and after pregnancy
2. Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence
3. Increase awareness and availability of family planning and STD prevention options
4. Promote awareness of childhood injury risks and provide injury prevention protocols to families and caregivers of children
5. Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options
6. Increase the proportion of mothers that exclusively breastfeed their infants at six months of age
7. Decrease disparities in maternal and infant mortality and morbidity
8. Promote healthy lifestyle options to decrease obesity and overweight among children and youth
9. Maintain specialty outreach clinics for children and youth with special health care needs
10. Improve the infrastructure for care coordination of children and youth with special health care needs

Changes in the MCH population:

New Mexico's population continues to struggle with poverty, geographic and cultural barriers to health care access, and low insurance coverage. There have been no major changes in the strengths and needs of New Mexico's MCH population during the last five years, however FHB recognizes that the long-term effects of the current recession may not yet be evident.

Changes in capacity

The program capacity in New Mexico has suffered from budget cuts resulting in the November, 2008 hiring freeze and subsequent staffing shortages. Children's Medical Services has been particularly hard-hit; nurses and clerks are exempted from the hiring freeze, but social workers are not.

Most of New Mexico's counties are considered to be Health Care Provider Shortage Areas. Since 2005, three hospitals stopped obstetric delivery services, and some providers have left the state or discontinued delivery services because of increasing liability insurance premiums, and low reimbursement rates.

Program and system capacity have increased in many areas. Obesity surveillance, legislation toward injury prevention and domestic violence reporting, laws supporting breastfeeding mothers

all reflect buy-in from the public, program staff and politicians on MCH-positive initiatives. The State is now one of five that is participating in piloting the Sudden Unexpected Infant Death Case Registry. (SUIDCR) New Mexico supports its birthing workforce through support for Doula programs, licensing midwives, and via financial support to offset medical liability insurance.

FHB and DOH are relying more on information technology such as the toll-free NurseAdvice hotline, and social marketing through text-messaging and web-based information-sharing to reach a greater number of New Mexicans.

FHB programs have successfully secured grant funding to support and pilot programs to address MCH needs. FHB and its partners are responsive to issues as they emerge, which during the previous needs assessment cycle resulted in the creation of the Maternal Depression Working group/pilot study, and the Senate Memorial 19 task-force on Prenatal Substance Abuse, among others.

Finally, New Mexico's MCH population continues to benefit from a strong community-based primary care system.

FHB does not yet know how the Patient Protection and Affordable Care Act will impact the State's capacity to provide services to the MCH population.

III. State Overview

A. Overview

PRINCIPAL CHARACTERISTICS AND THE HEALTH NEEDS OF NEW MEXICO MCH POPULATION

New Mexico's population is one of the most diverse in the United States, consisting of 44% Hispanics, 42% White, Non-Hispanic, 10% American Indians, 2% African-Americans, 1.4% Asian and Pacific Islanders, and 3.2% multi-racial. The state has the second highest percentage of Native Americans. Unfortunately, New Mexico also has high levels of poverty (18.1%) and uninsured individuals (21%). The state is one of the four poorest in the nation, with a median household income of $41,452. Over a third of New Mexico's population (36.5%) speaks a language other than English at home, the second highest percentage among all states. Reducing health disparities and increasing health equity are keys to addressing the health issues. Reducing these disparities in New Mexico requires enhanced efforts to raise awareness, collect and use data, mobilize communities, increase capacity, prevent disease, promote health, focus resources on targeted populations, and deliver appropriate care. Information on demographic characteristics is captured in most health systems, while socio economic data is not always available. Although health disparities exist across genders and socioeconomic and other strata, some of the most visible differences in health are among racial and ethnic groups.

By raising awareness to and prioritizing health disparities, the Department of Health identified three of its key indicators highlighting significant disparities: births to mothers ages 15 to 17, alcohol related deaths, and diabetes deaths. In addition to the disparity among different New Mexico populations, there also is a disparity between the national rate and New Mexico's higher rate for these key indicators:

SOCIO-DEMOGRAPHICS AFFECTING MCH WELL-BEING

According to the Census Bureau, in 2008 New Mexico had the highest percentage (45%) of Hispanics of any state with 83% of these native-born and 17% foreign-born.

POPULATION of New Mexico: In 2006-2008, New Mexico had a total population of 2.0 million - 995,000 (51 percent) females and 967,000 (49 percent) males. The median age was 35.8 years. 26 percent of the population were under 18 years and 13 percent were 65 years and older for people reporting one race alone, 70 percent was White; 2 percent was Black or African American; 9 percent was American Indian and Alaska Native; 1 percent was Asian; less than 0.5 percent was Native Hawaiian and Other Pacific Islander, and 14 percent was Some other race. Three percent reported two or more races. Forty-four percent of the people in New Mexico were Hispanic. Forty-two percent of the people in New Mexico were White Non-Hispanic. People of Hispanic origin may be of any race.

HOUSEHOLDS AND FAMILIES: In 2006-2008 there were 736,000 households in New Mexico. The average household size was 2.6 people. Families made up 65 percent of the households in New Mexico. This figure includes both married-couple families (46 percent) and other families (19 percent). Nonfamily households made up 35 percent of all households in New Mexico. Most of the nonfamily households were people living alone, but some were composed of people living in households in which no one was related to the householder. Source: American Community Survey, 2006-2008

NATIVITY AND LANGUAGE: Ten percent of the people living in New Mexico in 2006-2008 were foreign born. Ninety percent was native, including 51 percent who were born in New Mexico. Among people at least five years old living in New Mexico in 2006-2008, 36 percent spoke a language other than English at home. Of those speaking a language other than English at home, 79 percent spoke Spanish and 21 percent spoke some other language; 29 percent reported that they did not speak English "very well."

GEOGRAPHIC MOBILITY: In 2006-2008, 83 percent of the people at least one year old living in New Mexico were living in the same residence one year earlier; 10 percent had moved during the past year from another residence in the same county, 3 percent from another county in the same state, 4 percent from another state, and 1 percent from abroad.

EDUCATION: In 2006-2008, 82 percent of people 25 years and over had at least graduated from high school and 25 percent had a bachelor's degree or higher. Eighteen percent were dropouts; they were not enrolled in school and had not graduated from high school. The total school enrollment in New Mexico was 532,000 in 2006-2008. Nursery school and kindergarten enrollment was 56,000 and elementary or high school enrollment was 332,000 children. College or graduate school enrollment was 145,000.

INDUSTRIES: In 2006-2008, for the employed population 16 years and older, the leading industries in New Mexico were educational services, health care, and social assistance, 23 percent, and retail trade, 12 percent.

INCOME: The median income of households in New Mexico was $43,202. Seventy-nine percent of the households received earnings and 19 percent received retirement income other than Social Security. Twenty-eight percent of the households received Social Security. The average income from Social Security was $13,895. These income sources are not mutually exclusive; that is, some households received income from more than one source.

POVERTY AND PARTICIPATION IN GOVERNMENT PROGRAMS: In 2006-2008, 18 percent of people were in poverty. Twenty-five percent of related children under 18 were below the poverty level, compared with 13 percent of people 65 years old and over. Fourteen percent of all families and 35 percent of families with a female householder and no husband present had incomes below the poverty level. Quickfacts.census.gov

Teen Births: The birth rate to New Mexicans ages 15 to 17 has declined over the years but not as quickly as the national rate. Consequently, the gap between the New Mexico rate and the national rate remains. Births to teens are associated with not only negative consequences for the children and their parents but also public costs.

Although anyone older than 12 and younger than 20 is a teen, in the case of early parenthood, the emphasis is on reducing the incidence for girls who are or should be in school. Hispanic teens have the highest birth rates both in New Mexico and nationally. Before 1995, blacks had the highest teen birth rates nationally, but the black teen birth rate declined 59% from 1991 to 2005. This is compared with only a 22% decrease for the national Hispanic teen birth rate.5 Although Hispanics constitute almost half the female population of 15-to-17-year-olds in New Mexico, their share of teen births is higher, with more than 70% of the births in this age group occurring to Hispanics. Fifty-four out of every thousand Hispanic females ages 15 to 17 in New Mexico give birth in any given year. The Hispanic birth rate is consistently higher than that of the other major population groups in New Mexico, and more than twice the national rate. The teen birth rate for New Mexico Hispanics is four times the rate for non-Hispanic White New Mexico teens and 75% higher than that of American Indians.

Alcohol-related Death: New Mexico consistently has one of the highest alcohol-related death rates in the nation. Such deaths disproportionately impact American Indians. Although it appears that the rate may be declining, the alcohol related death rate for American Indians continues to be substantially higher than that of other populations in New Mexico (Figure 2). In fact, the disparity may be increasing, as the alcohol-related death rates for other New Mexico populations appear to be falling more rapidly. Nearly 17% of all alcohol-related deaths occur to American Indians, who make up less than 10% of the population.

The two principal components of alcohol-related death are those due to chronic diseases that are strongly associated with chronic alcohol abuse, such as liver disease, and deaths due to alcohol

related injuries such as motor vehicle accidents, which are strongly associated with acute alcohol abuse. The high rate of alcohol-related deaths for American Indians reflects both components. A recent national report6 shows the extent to which alcohol accounts for many preventable deaths and years of life lost in the American Indian population.
Diabetic Death: American Indians have the highest rate in New Mexico of deaths due to diabetes. Similar to the trend of alcohol-related deaths, the diabetes death rate for American Indians appears to be decreasing but remains substantially higher than the rate for other populations in New Mexico. Despite the diabetes initiatives of the Indian Health Service, including the development of best practices and model programs, American Indians continue to experience both a high death rate and a high rate of amputations due to diabetes. 7 Hispanics also have a high diabetes death rate and one that is well above the rate of all New Mexico populations other than American Indians (Figure 3).

Population: The United States Census Bureau, as of July 1, 2008, estimated New Mexico's population at 1,984,356, which represents an increase of 165,315, or 9.1%, since the last census in 2000. This includes a natural increase since the last census of 114,583 people (that is 235,551 births minus 120,968 deaths) and an increase due to net migration of 59,499 people into the state.

Immigration from outside the United States resulted in a net increase of 34,375 people, and migration within the country produced a net gain of 25,124 people. 7.2% of New Mexico's population was reported as less than 5 years of age, 28% under 18, and 11.7% were 65 or older. Females make up approximately 50.8% of the population.

Preconception and Prenatal Health: From before conception through the first year of life, the health of New Mexico's women and babies depends on many factors including good nutrition, timely access to adequate and appropriate clinical services, health insurance coverage, and a safe home environment. In 2006, 45% of all New Mexico women who gave birth did so after an unintended pregnancy. Preconception health means planning one's pregnancy, avoiding tobacco and alcohol, and taking folic acid before becoming pregnant. Health experts recommend that women of child-bearing age take 400 micrograms of folic acid (a B vitamin) in a multi-vitamin every day. If taken before conception and throughout pregnancy, folic acid can prevent serious birth defects in a baby's brain and spine. Sixty two percent of New Mexico mothers who gave birth in 2006 never took a multivitamin, compared with 25% who reported taking a multivitamin every day.

Adequate prenatal care is measured by the number and timing of clinical visits, and is associated with healthy pregnancy. Infants born to mothers with low levels of prenatal care are five times more likely to die in the first 27 days of life. In 2006, 11% of women in New Mexico received little or no prenatal care (defined as care that starts in the last trimester, or fewer than five visits). The prenatal care status of 6% of women was unknown. Women in southwest New Mexico were most likely to receive low or no prenatal care.

Maternal Health: Nine percent of women who gave birth in 2006 reported that they had been abused by their current or former partner before they became pregnant, and 5% reported that they were abused during pregnancy. In that same year, 19% of mothers reported experiencing postpartum depression. Fifty-nine percent of mothers reporting postpartum depression were Hispanic, 26% were Anglo, and 16% were Native American. Of all women who experienced symptoms of postpartum depression, 20% reported that they had been abused by their current or former partner.

In 2006, the New Mexico Women, Infants, and Children program's nutrition services aided 46% of women who had a live birth. The number of women served was 13,733, and the number of infants and children served was 66,575. In the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) survey, 12% of women reported that they "sometimes" do not have enough food to eat. Two percent reported that they "often" do not have enough food to eat.

In 2005, 59% of New Mexico births were paid for by Medicaid. In 2005 and 2006, 15% of women from ages 19 to 64 in New Mexico had no health insurance.

Infant Health: From 2004 to 2006, the infant mortality rate in New Mexico was 5.8 per 1,000 live births, which was lower than the national rate. The lowest infant mortality rate was among the Hispanic population. The rate was 2.5 times higher for African-Americans, 1.5 times higher for Native Americans, and 1.1 times higher for White, non-Hispanics.

Breastfeeding: Recent studies show that babies who are not breastfed exclusively for six months are more likely to develop ear infections, diarrhea, and respiratory illnesses, and to have more hospitalizations. Infants who are not breastfed have a 21% higher post-neonatal mortality rate in the U.S. For mothers, breastfeeding lowers the risk of breast and ovarian cancers, and possibly the risk of hip fractures and osteoporosis after menopause as well. According to results from the National Immunization Survey of children born in 2003 and 2004, 33% of New Mexico mothers exclusively breastfed their babies for at least three months, and 14% exclusively breastfed for at least six months.

In 2007, the workplace breast pump bill was passed, requiring New Mexico employers to provide a clean, private space that is not a bathroom where a mother can pump breast milk for her baby. The space must be near the employee's workspace, and the bill also requires that employers allow mothers flexible break times for pumping milk.

Exposing infants to cigarette smoke is a risk factor for respiratory illness and Sudden Infant Death Syndrome (SIDS). Ninety-four percent of mothers in the 2006 PRAMS survey reported that their babies were never exposed to second-hand smoke, and 6% reported that their infants were exposed to second-hand smoke at least one hour per day. Seventy six percent of 19-to-35-month-olds received a full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, and pertussis in 2006.

Placing babies on their backs to sleep reduces the risk of SIDS, also known as "crib death." In 2006, 62% of PRAMS survey mothers reported that they placed their babies on their backs to sleep. Twenty-three percent placed their babies on their sides, and 10% placed them on their stomachs or used a combination of positions.

Oral health is integral to overall health. Oral health means much more than healthy teeth. It means being free of chronic oral-facial pain conditions, including throat cancers, oral soft tissue lesions, birth defects such as cleft lip/palate and other diseases. Many people may suffer from tooth decay, periodontal disease, and other chronic oral conditions and injuries. Preventive measures include good oral hygiene practices, regular visits to a dental provider, consumption of fluoridated water, eating healthy, and the use of preventive measures such as dental sealants. Poor oral health in children, young people and in adults may result not only in dental decay, eventual tooth loss, and impaired general health, but also in compromised nutrition.

Prevention: The United State Surgeon General reported that "dental caries [tooth decay] is the single most common chronic childhood disease, five times more common than asthma and seven times more common than hay fever." Oral disease can be prevented through good nutrition and oral hygiene practices, drinking fluoridated water, smoking cessation, and regular visits to a dental provider. Fluoride protects teeth via the water supply for children during the tooth forming years and by direct contact with teeth throughout life. Community water fluoridation is the controlled addition of a fluoride compound to a public water supply to achieve a concentration level optimal for the prevention of tooth decay. Topical fluoride is an important source of prevention of tooth decay.

The 2006 New Mexico Oral Health Surveillance Survey reports that 76% of New Mexico water systems are fluoridated but only 18% received water with the appropriate levels adequate for

preventing dental caries. Dental sealants are thin plastic coatings applied to the chewing surfaces of the molars to prevent decay. Most tooth decay in children and adolescents occurs on these surfaces. Permanent molars are the most likely to benefit from sealant application. In 2007, 1,100 New Mexico 3rd grade children received a dental sealant.
Tooth decay is one of the most common chronic infectious diseases among U.S. children. This preventable health problem begins early as 28 percent of children aged 2-5 years already have decay in their primary (baby) teeth. By the age of 11, approximately half of children have experienced decay, and by the age of 19, tooth decay in the permanent teeth affects 68 percent of adolescents. New Mexico low-income children experienced twice as many untreated cavities as children in families with higher incomes. In 1999-2000 an oral health survey of NM third graders conducted by the Department of Health estimated that 43.2% had one or more sealants on their permanent first molar teeth, 64.6% had caries experience, and 37.0% had untreated decay.

Children and adults with disabilities and people with mental illness tend to have fewer teeth, more untreated decay and more periodontal disease than society at large. Individuals with disabilities have the same entitlement to good oral health as the rest of the population. A number of oral health prevention and treatment programs throughout the state serve individuals with disabilities.

The 2008 Legislature approved the Birthing Workforce Retention Fund which provides malpractice premium assistance for providers. Funds were also appropriated for domestic violence programs, childhood immunizations, and contraceptive cost increases.

The NM SAFE KIDS Coalition provided car seat clinics, including free car seat checks and/or seat replacements for infants and children.

The NM Breastfeeding Task Force, a coalition of roughly 100 individuals interested in breastfeeding, worked to increase the frequency and duration of breastfeeding in New Mexico.

The NM Statewide Immunization Information System, a web-based database with immunization records of New Mexico children, helped ensure that they are current with their recommended schedules of vaccination.

New Mexico continues to strive to ensure that all New Mexico women and children have enough nutritious food to eat, that all women and children have comprehensive health insurance that includes mental health services, that women are provided culturally appropriate prenatal care for hard-to-reach rural and frontier populations, that healthy mother-infant relationships and breastfeeding through extended paid maternity leave for all new mothers are encouraged, and that services for women leaving abusive relationship are provided.

There are multiple factors that determine the health and wellness of children: physical, social, emotional, economic, educational, and environmental. Unfortunately, New Mexico children rank 48th in child well being according to the Annie E. Casey Foundation's annual KIDS COUNT Data Book 2008.

Twenty-six percent of children under the age of 18, including 29% of children under the age of 6, live in families with incomes below the federal poverty level. 41% of children under the age of 18 live in families where no parent has regular, full-time employment. 29% of children ages 10-17 are overweight or obese and 51% of children ages 6-17 do not exercise regularly. 8% of children under the age of 18 were affected by asthma during the past year. 14% of children ages 0-5, and 19% of children ages 6-17 were not covered by health insurance at any point during the past year.

New Mexico ranks second in the nation, along with Florida, for the highest percentage of children without health insurance. Through an aggressive outreach and enrollment campaign over the past two years, the number of children eligible for and enrolled in the State Children's Health

Insurance Program (SCHIP) and Medicaid are at an all-time high. As of May 2008 195,711 children (birth to age 12) were enrolled in Medicaid or SCHIP.

New Mexico Medicaid provides many health services for children under a federal Medicaid policy which requires that children receive Early Period Screening, Diagnostic, and Treatment (EPSDT). This policy includes preventive health services, maintenance health services, and treatment of medical conditions. It also includes mental health or behavioral health services. Children may go to a doctor, a nurse practitioner or a physician's assistant for a well-child exam and do not need to have a specific complaint to be seen.

Children with Special Health Care Needs: In 2005-2006, the second national survey of Children with Special Health Care Needs (CSHCN) estimated that 12.1% (59,535) of New Mexico children have special health care needs. A positive finding from the survey was the percent of children in New Mexico who were screened early and continuously for special health care needs (64.1%). The survey showed that while New Mexico has experienced improvement in several categories since the first survey in 2001, families continue to need increased coordinated, family centered, community based care. Due to a scarcity of providers, economic hardship, lack of or under-insurance, agencies and providers continue to strive towards addressing the need.

Data from two National Health and Nutrition Examination Surveys (NHANES) show that during the past 30 years, prevalence of overweight for children aged 2-5 increased from 5.0% to 13.9%. For those aged 6-11, prevalence increased from 6.5% to 18.8%. In 2007, 10.7 percent of New Mexico children under age five were overweight. Among children age two and under, 14.5% were considered to be "at risk" for overweight, while 12% were overweight. Rates in New Mexico were slightly lower than national rates for that year. Approximately 50% of New Mexico children ages 2-5 are served by the WIC program. In 2007, 5.4% of these children were underweight, 13.6% were overweight, and 12.7% were obese. From 2006-2007 there was a 3.4% increase in the number of WIC children who were overweight and a 5.8% increase in the number who were obese. Childhood overweight is associated with various health-related consequences including psychosocial risks, cardiovascular disease risks, asthma, sleep apnea, and Type 2 diabetes.

In spite of the fact that the overall well being of some children in New Mexico is poor, good things are happening. Screening children early and often allows for diagnosis, referral, and treatment of developmental delays and other disabilities and disorders, affording more positive short and long term outcomes. Medicaid reimburses providers for certain screenings, and more children are now eligible for Medicaid. While the percentage of overweight children is increasing, the issue is a priority for the Governor and is being addressed by state agency programs.

The Early Childhood Action Network (ECAN) is a statewide policy forum that makes recommendations on how to improve the well being of young children from birth to five and their families. ECAN supports the Family Leadership Action Network (FLAN), an initiative designed to promote parent involvement and build family leadership in shaping the system that impacts their lives and their children's future.

The Developmental Screening Initiative (DSI) at UNM solicits input from many stakeholders across the state to promote best practices in developmental screening for children birth to five years of age. New Mexikids (Children's Medicaid and State Children's Health Insurance Program) covers children through 18 years of age with household incomes up to 235% of the Federal Poverty Level. New Mexico needs to continue outreach to increase the number of children covered by New Mexikids to promote Early Periodic Screening, Diagnostic, and Treatment (EPSDT) for all children, increase coordinated, family centered, community based care for children and families, and encourage health providers to practice in underserved areas of New Mexico.

Natality: There were 30,605 births to New Mexico resident mothers in 2007, translating to a birth rate of 14.9 births per 1,000 population. New Mexico's birth rate has declined from a rate of 19.1

in 1985. In 2006, the latest year for which United States data is available, the national birth rate was 14.2, a slight increase from the 2002 birth rate of 13.9, a record low for the United States. The state birth rate has been consistently higher than the national rate, although since 2000 New Mexico's rate has dropped closer to that of the United States New Mexico Selected Health Statistics Annual Report, Volume 1, 2007

N.M. DEPARTMENT OF HEALTH PRIORITIES AND TITLE V MCH PROGRAM ROLES AND RESPONSIBILITIES

New Mexicans require access to basic health care services to maintain their health. Lack of access to key services is a cause of unnecessary disease and mortality. If basic health care services are not accessible, people may postpone seeking treatment until they become seriously ill. In addition, screening and health education conducted in clinical settings are important preventive services.

The DOH under the direction of the new Cabinet Secretary, Dr. Alfredo Vigil, restructured its Strategic Plan and is priorities for FY 2011. The Department's priorities
were restructured to include goals with objectives to address each goal. The goals and the objectives are:

Goal 1: Improving Individual Health
Individual Objective 1:
Increase immunizations for all New Mexicans, especially for children and adolescents.
Individual Objective 2:
Reduce teen births.
Individual Objective 3:
Increase the proportion of new mothers who had recommended levels of health care before, during and after pregnancy to assure optimal physical, mental and oral health.
Individual Objective 4:
Decrease the transmission of infectious diseases and expand services for persons with infectious diseases.
Individual Objective 5:
Reduce suicide among all populations, specifically children and adolescents.
Individual Objective 6:
Reduce the abuse of alcohol, drugs and tobacco.
Individual Objective 7:
Ensure quality developmental disabilities services and improve outcomes for New Mexicans with developmental disabilities.

Goal 2: Improving Community Health
Community Objective 1:
Reduce health disparities in New Mexico.
Community Objective 2:
Prevent and control chronic diseases.
Community Objective 3:
Reduce obesity and diabetes.
Community Objective 4:
Reduce intentional and unintentional injury.
Community Objective 5:
Ensure preparedness for health emergencies, including pandemic influenza.
Community Objective 6:
Identify and reduce environmental exposures which adversely impact public health.

Goal 3: Improving the Health System
System Objective 1:
Improve accountability and responsiveness of our services within the Department of Health.

System Objective 2:
Expand health care for school-age children and youth through school-based health services.
System Objective 3:
Create an oral health system that provides children, low-income rural populations and people with developmental disabilities with preventive and restorative oral health services.
System Objective 4:
Improve emergency medical services and the trauma care system across the state.
System Objective 5:
Improve the scientific laboratory's ability to provide laboratory analytical services to state programs.
System Objective 6:
Improve resident care services in Department of Health facilities.
System Objective 7:
Eliminate abuse, neglect or exploitation of seniors and vulnerable adults.
System Objective 8:
Increase the number of state licensed providers who receive a regular and periodic review of provider compliance.
System Objective 9:
Improve recruitment, retention and training of health care providers in rural, American Indian and border communities.
System Objective 10:
Increase use of technologies to improve health outcomes.

The 2011 Department of Health Strategic Plan incorporated three new Objectives that reflect an increasing demand in the following areas:
Reduce intentional and unintentional injury: Injuries are the leading cause of death among people ages 1 to 44 in New Mexico. Each day, an average of five people die from injuries, another 40 are hospitalized due to injuries; more than 700 are seen in emergency departments, and more that 2,000 visit other health care facilities for treatment of their injuries. Most are preventable. As with chronic disease, we must reach beyond individual education.

New Mexico's deaths by unintentional injury ranked 3rd in the nation in 2005, with a rate of 66.3/100,000 population. However, the main causes of unintentional injury death vary by age group: Drowning or motor vehicle crashes led among children 0-4 years. Motor vehicle crashes were the main cause of death among the 5 to 24 year age group. Poisoning death led among the 25-64 year age group. Fall deaths were most common among the elderly. An estimate of non-fatal injuries for 2004-2006 showed that prior to age 65 years, a variety of injuries led to hospitalization. Among persons 65 years and older falls were the most common cause of injury hospitalization. The big success story in unintentional injury prevention of the last 25 years has been the reduction in deaths and injuries from motor vehicle crashes. The state has invested in well-enforced seat belt and child safety seat laws, initiated child helmet use laws, set tighter standards against drinking while driving, and improved roadway design. From 1985 to 2006, the NM crash death rate declined 29%, and the alcohol- involved crash death rate decreased 59%. The state's seat belt-use rate is over 90%. Still, motor vehicle crashes were the cause of 25% of all injury deaths in 2006 and of those killed 43% were not restrained by a safety belt.
Ongoing promotion of child seat and seat belt use, and increasing recognition that booster seats can improve safety for 5-11 year olds in motor vehicles, receives strong public and private sector support. Two-thirds of all injury deaths in New Mexico are from unintentional causes, motor vehicle crashes, poisoning (primarily drug overdose), and falls. These are often called "accidents" although most are predictable and often preventable. From 2004 through 2006 these three causes accounted for 86% of all unintentional injury deaths, a 3.5% increase from the 1999-2002 period.

Head injuries are among the most disabling, as they can lead to loss of independence and create the need for costly caregiver and support services. An estimated 36,000 New Mexicans currently live with a disabling brain injury. Increased collection of non-fatal injury data would improve

understanding of the impact of brain injury in the state. Approximately 1,069 New Mexicans were hospitalized with a traumatic brain injury in 2006. Many fatal or disabling head injuries from riding bicycles, skateboards, scooters, skates, horses, and all terrain vehicles can be prevented by the use of helmets. Statewide promotion and education initiated through the Off Highway Vehicle Safety Board since 2006 and the NM Helmets for Kids Coalition since 2007, have helped to inform citizens about the importance of complying with these laws for the protection of their families.

Prevent and Control Chronic Diseases: Heart disease, cancer, stroke, lung disease and diabetes are responsible for six out of every ten deaths in New Mexico. Arthritis is the top cause of disability for New Mexico adults. Although chronic diseases are more common among older adults, they affect people of all ages. Many chronic diseases are at least partly preventable. Preventing disease requires improving the health status of people at every stage of life. Such a task is not possible one person at a time; it can be achieved only by improving the surrounding social and physical environments, such as access to recreational areas, affordable healthy foods, clean air, and work and educational opportunities.

Increase the proportion of new mothers who had recommended levels of health care before, during, and after pregnancy to assure optimal physical, mental and oral health: The incidence of birth defects and low birth weight are decreased when women receive good health care before, during and after pregnancy. New Mexico ranks in the bottom 5% of states for care beginning in the first three months of a woman's pregnancy. This ranking is due to many factors, including education and poverty levels, lack of providers in rural areas and disinterest on the part of some pregnant women to seek prenatal care. In FY11, the Department of Health will place an added effort on addressing those factors. We will also work to expand oral health care services. Evidence suggests that most young children who have the bacteria that cause tooth decay got it from their mothers, who experienced poor oral health during pregnancy.

HEALTH CARE COVERAGE AND ELEMENTS OF THE NM SAFETY NET: some of the NM population has no health insurance coverage for a variety of reasons including but not limited to immigrant status and employment without insurance coverage. The safety net for direct health services is comprised of the following:
County Indigent Funds: each county has specific criteria for eligibility. In the 2005 needs assessment, county level public health professionals cited the difficulties for families who may move from one county to another.
State General Fund, Healthier Kids Fund: this fund, $800,000 in 2004, is administered by Children's Medical Services (CMS) and purchases services for primary care needs of children who have no possible source of coverage.

Title V MCH Block Grant, Children's Medical Services (CMS): funds are used to procure high risk insurance for children who have no coverage, and who have serious conditions requiring specialty care.

Title V MCH Block Grant, High Risk Prenatal Fund: funds are used directly and cover prenatal and delivery costs for women at high risk and have no possible source of coverage.

NM Department of Health, MCH Services in Local Health Offices: selected Maternal Health services are offered in areas where there are no prenatal or well child providers; case management for children with special health care needs and family planning clinical services are offered in every count. Registration does not include residential status and DOH policy forbids denial of service based on race, ethnicity, age, sexual orientation or other potential reasons for a person to feel marginalized or the object of discrimination.

Maternal Health Services in Federally Qualified Health Centers and Community Health Centers: limited Maternal Health services, particularly prenatal care, are offered due to provider preferences, training and the cost of malpractice insurance.

What Is Primary Care?

Primary care is defined as basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social.1 Medical care is the focal point of primary care services; integrated preventive, dental, and behavioral health services also are components. The aim of primary care is to assure coordinated entry into the health care system.

Barriers to Access

Several barriers can prevent individuals from receiving the basic care they require. Important ones include: geographic barriers which are created by substantial distances to the nearest source of primary care services and financial barriers. Individuals may have inadequate resources to secure all the basic health services they need. Even those with health insurance may not have adequate coverage. Co-payments, deductibles, and limitations on scope of coverage may make even insured individuals have problems affording medical coverage. It also is not uncommon for people with medical insurance to have inadequate resources for dental or behavioral health needs.

Linguistic and Cultural Barriers

When health care services are not provided in the language of a patient, individuals may not actively seek these services. In addition, the services may not be effective even if patients seek them, particularly if patient education must be provided about follow-up and self-care. Similar barriers can exist if health care providers are not culturally competent and act in ways that patients do not understand. The efforts of the Department of Health and other public agencies are designed to reduce these barriers to basic health care, with a focus on the high-risk underserved, including uninsured New Mexicans, rural/frontier populations, minority populations, and the homeless and migrant/farm worker populations.

Access to Basic Health Care

A significant portion of New Mexicans are at risk for lack of access to needed primary care. The federal government has designated all or part of 30 of the state's 33 counties as Health Professional Shortage Areas (HPSAs) for medical services. More than 700,000 people live in these areas. Similarly, the federal government has designated all or part of 26 of the state's counties as HPSAs for dental services, with over 700,000 New Mexicans living in these areas.2 While not everyone in the HPSAs is without care; many people clearly get less health care than they need.

New Mexicans living outside HPSAs also face access problems. The state has one of the highest percentages of population without health insurance. In 2007, 22% of its adults had no health insurance, compared with 14% in the entire United States. During the same period, 26% of the non-elderly adults in the state had no health coverage, compared with 17% for the country as a whole. Among adults with health care coverage, only 8% reported that cost had kept them from obtaining necessary medical care in the previous year, while cost prevented 42% of those without coverage from obtaining necessary care in the same year.2

The impact of the lack of health care coverage can be demonstrated by comparing use of important clinical preventive services by those who have health care coverage with their use by those without such coverage. From 2004 through 2006, 77% of women ages 50 or older with health care coverage reported having a mammogram in the previous two years, while only 47% of those without coverage reported a mammogram in that period. During the same time span, 55% of adults 50 or older with health care coverage reported having had a screening endoscopy for colorectal cancer, while only 26% of those without coverage reported having had an endoscopy for this purpose. Among adults with diabetes, 49% of those with health care coverage reported receiving all recommended diabetes management services in the previous 12 months,

while only 30% of those without coverage met this important standard.

Adults without coverage also may have greater need for coverage. In 2007, those without coverage were more likely to smoke tobacco and report binge drinking of alcohol, and were less likely to report leisure-time physical activity than adults with coverage.

Community-Based Primary Care
For more than 20 years, there has been an effort to build a system of community-based primary care centers for New Mexico's underserved. This has been a collaborative effort, linking federal, state, and local programs with community groups and non-profit agencies. The impact has been considerable; there are primary care centers in more than 85 underserved communities in the state. Most of these are operated by non-profit agencies; all are governed by local boards dedicated to meeting the primary care needs of their communities.
Collectively, these centers serve more than 290,000 patients--14% of the total New Mexico population. They also generate more than 900,000 patient visits, including medical, dental, and other primary care service visits.
Centers operate in both urban and rural areas. More than 80% of the clinical locations are in rural and frontier areas, reflecting the state's non-urban nature. More than 70% of the patients that these centers serve are either uninsured or supported by Medicare or Medicaid. This also reflects the health safety net nature of the primary care center sector.

Improving Access
Primary care centers are serving approximately half of the unmet need in New Mexico, making clear the necessity of continuing to build the primary care center sector. Under the Federal Primary Care Cooperative Agreement, NMDOH will continue its work facilitating the expansion of primary care centers. While the focus of these centers is on medical services, there is an increased emphasis on expansion of dental services in the primary care setting. Fewer than half of primary care clinic sites have dental service capacity. But even with this limited capacity, primary care centers provide more than 20% of all Medicaid dental services in New Mexico.
The community-based primary care sector in New Mexico is a major public health success story. Few other states have as widespread a system caring for such a large percentage of the state's underserved population. The sector has been built upon local initiative, community governance, federal, state, and local financial support, and staffing from government health professional programs.

What's Being Done
Community-based primary care centers are being funded. Physicians, dentists, and other health care providers are being recruited, and community-based primary care centers are receiving retention assistance. Low-interest loans are being granted for community-based primary care center facilities and equipment. Planning assistance is being given to community groups and agencies developing or expanding community-based primary care centers.

What Needs to Be Done
Expansion of primary care centers to meet the needs of more underserved people. Continue to strive for the expansion of dental services for primary care center clients. Expansion of basic behavioral health services within the primary care setting and expansion of health promotion and disease prevention services and chronic disease management capacity in the primary care centers.

B. Agency Capacity

III B 1: Office of the Bureau Chief/Title V Director

As noted in the overview New Mexico's population is one of the most diverse in the United States, consisting of 44% Hispanics, 42% White, Non-Hispanic, 10% American Indians, 2% African-Americans, 1.4% Asian and Pacific Islanders, and 3.2% multi-racial. The state has the second highest percentage of Native Americans.

The Department of Health 2011 Strategic Plan Community Health Objective 1: Reduce Health Disparities; addresses cultural competency in 5 of the 9 strategies.
Cultural competency is focused throughout services provided in the Maternal Health (MH) program. Prenatal care focuses on meeting the needs of the Mexican & Native American women. Ten local Public Health Offices provide Prenatal Care (PNC), & each has native Spanish-speaking clinical staff or translation services available for clients. The MH program also contracts with private providers to provide MH services, each of these providers have Spanish speaking clinical staff or translation for clients who are Spanish speaking only, and where possible, for clients who speak other languages.

The MH program also promotes Facilitated Group PNC to improve cultural relevance for all women. This model has proven valuable by increasing satisfaction, increased attendance & increasing breastfeeding & self care initiatives. Six clinics have been established for Spanish speaking women. Another two agencies provide Facilitated Group PNC exclusively for teen mothers & their partners. All Educational materials are translated.

The Family Planning program provides training to health offices & contractor staffs to assure services are culturally appropriate.

The DOH website will post the Limited English Proficiency policy & a statewide list of translator/interpreter resources.

I think the website has good info. We can add the Mandated CLAS Standards and then refer to the Strategic Plan website.

Mandated CLAS Standards
Standard #4: Health care organizations must offer & provide language assistance services, including bilingual staff & interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
Standard #5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
Standard # 6: Health care organizations must assure the competence of language assistance provided to limited proficient patients/consumers by interpreters & bilingual staff. Family & friends should not be used to provide interpretation services (except on request by the patient/consumer).
Standard #7: Health care organizations must make available easily understood patient-related materials & post signage in the language of the commonly encountered groups &/or groups represented in the service area.

III B 2 Maternal and Child Health

The Maternal Health Program (MH) focuses cultural competency in prenatal care (PNC) on meeting the needs of Hispanic and Native American women. The ten Public Health Offices providing PNC each have Spanish-speaking clinical staff or expert translation available for clients. A Nurse Practitioner and Physician both originally from Mexico serve three of these ten clinics. Maternal Health contractors provide Spanish-speaking clinical staff and/or expert translation for Spanish speaking clients and other non-English speaking clients. Printed client education resource materials provided by MH are made available in both English and Spanish.

Focus groups of Hispanic and Navajo women, young and old, urban and rural, have guided PNC promotion. MH actively promotes the model of Centering Pregnancy, a facilitated group PNC approach, designed to improve cultural relevance for all women. This model has been proven to increase satisfaction with and attendance at PNC, as well as self-care and breastfeeding. MH assisted six clinics to develop Centering groups for Spanish-speaking women. Two agencies in Albuquerque provide Centering care exclusively for teen mothers, their partners and support persons. Efforts to support Indian Health Service clinics in starting a group PNC option continue. MH, Public Health Offices, and community partners continually collaborate to identify cultural barriers to PNC, and to eliminate them.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants:

In 2007, over 58% of New Mexico's pregnant women and infants had care paid by Medicaid and S-CHIP through its Managed Care Organizations (MCOs) and fee-for-service sites. The Maternal Health Program (MH) directly and indirectly oversees prenatal care services through a variety of programs and provider agreements. In 10 of the 54 public health offices (PHO) direct prenatal care services are provided for about 800 women who are financially or geographically unable to obtain prenatal care in the private sector. MH administers the High Risk Prenatal Care Fund (HRF) contracting with 21 qualified private care providers, clinics and hospitals throughout the State to care for more than 1200 medically indigent women with high-risk perinatal conditions per year. The HRF also contracts with the University of New Mexico Hospital (UNMH) to provide prenatal care to high and low-risk medically indigent women in Albuquerque, and to any patients referred to them from providers throughout the state. This care includes high risk outreach clinics in 5 counties, prenatal laboratory services, ultrasounds and other perinatal testing as indicated. A similar Maternal Health Program agreement uses New Mexico General Funds to pay for perinatal services for more than 150 medically indigent women in Las Cruces.

MH indirectly provides for prenatal care through the licensing and regulation of midwifery care in NM. MH regulates both Licensed Midwives (LM) and Certified Nurse Midwives (CNM). MH heads advisory boards for both types of midwives, meeting quarterly to review regulations, policy and disciplinary actions. In 2007, over 33% of births in New Mexico were attended by midwives, and untold hours of prenatal and postpartum care were provided by these midwives.

In late 2008, Maternal Health Program did a survey of delivery services in each of New Mexico's 33 counties. 12 of the 33 counties have no hospital that provides delivery services except in emergencies. 11.6% of the state's births in 2006 were to residents of these counties. A survey of physicians by the New Mexico Health Policy Commission in 2001 showed that 13 (40%) New Mexico counties lacked an Ob/Gyn practicing obstetrics. In 2006, a repeat of the survey showed that 17 (51%) counties lacked an Ob/Gyn practicing obstetrics. Between 2005 and 2008, three hospitals terminated delivery services. Only 9 counties have providers for out-of-hospital deliveries.

Increasing liability insurance premiums and low reimbursement rates have driven some providers to leave the state or to quit providing obstetric services. In 2008 the legislature approved the Birthing Workforce Retention Fund which is administered by the Maternal Health Program. This fund provides up to $10,000, per provider, to help defray the cost of malpractice insurance for some qualified rural perinatal health care providers. Additionally, the state participates in the development of proposals for alternatives to the torts system for compensating those who suffer poor birth outcomes and for reducing negligent practice. The goal being that such an administrative systems could reduce the burden of liability insurance costs and the stresses of litigation, thus potentially increasing the number of obstetric providers and the public access to servicese.

The Families FIRST Program (FF) will join the MCH Section. FF receives no Title V funds; it is supported by contracts with the MCOs. The goals and activities of the FF Program fit with those

of the MCH Section. Partnering with FF will strengthen the Section's ties to direct services. FF provides case management for Medicaid-eligible pregnant women and children 0-3 years. Its goals are to improve birth outcomes, to decrease high-risk pregnancies and identify children with special health care needs for early intervention. FF case managers conduct verbal assessments of the mother and child's health including emotional, social, educational and other needs. The FF CMs refer clients to needed services, including nutrition counseling, parenting classes, and education sources. FF has contracts with the three Medicaid MCOs. It has case management providers in 45 sites. The number of clients served increased by about 80% from 7/01/01-6/30/04.

III B. 3. Maternal and Child Health Epidemiology

The Maternal and Child Health Epidemiology program collects, analyzes and reports on maternal, infant and child health for special populations throughout New Mexico. Ongoing reports describe the health status of Native American, U.S. Mexico Border, and Hispanic women and children. Survey tools are translated into Spanish by a professional translator with the New Mexico Department of Health or with the Centers for Disease Control and Prevention. The NM PRAMS survey is conducted in both Spanish and English, statewide, and within NM tribal boundaries to include data collection among Navajo, Pueblo, and Apache women. County-level PRAMS data are readily available through geographic sample stratification to ensure survey participation in each Public Health region. The MCH Epidemiology program (PRAMS) and the Navajo Tribal Epidemiology Center maintain data sharing agreements, and collaborate on Navajo-specific PRAMS surveillance reports. Representatives from Navajo-area Indian Health Service and NM's two Tribal Epidemiology Centers actively participate in the PRAMS Steering Committee. Behavioral Health Collaboratives participate with the multidisciplinaryNM Maternal Depression Work Group to bring PRAMS data and information regarding perinatal depression to medical and mental health service providers in several areas of the state, including U.S./Mexico Border counties and the Navajo Nation. The workgroup was developed to address the prevalence of postpartum depression among NM women giving live birth. NM PRAMS and Tewa Women United share data and prepare reports, grants and community improvement projects together to improve the health of Native American families in Northern New Mexico. New Mexico and the Navajo Nation work to coordinate their Youth Risk Behavior Survey (YRBS) so that respondents and administrators avoid "survey fatigue," and the Navajo YRBS plans to incorporate many of New Mexico's resiliency questions into future Navajo surveys. Vital Records birth and death files are regularly examined to assess racial and ethnic disparities in Maternal and Child Health outcomes.

III. B. 4. Family Planning

NM DOH FPP has served as the NM grantee for the Federal Title X of the Public Health Service Act fund for more than 20 years. Family Planning is an integral component of the NM DOH's efforts to reduce teen pregnancy, prevent unintended pregnancy and sexually transmitted infections (STIs), prevent recourse to abortions, reduce infant mortality and morbidity, and improve the health of women and men of all ages. In NM, 237,020 women are in need of contraceptive services. Of these women, 139,520 need publicly supported contraceptive services because they have incomes below 250% the federal poverty guidelines (107,100) or they are sexually active teens (32,420) [Alan Guttmacher Institute. (2009). Contraceptive Needs and Services, 2006. Retrieved February 2, 2010, from www.guttmacher.org/pubs/win/index.html]. In 2009, NM DOH FPP provided clinical services to 45,693 people, 37,683 female clients and 8,010 male clients. Clinical reproductive health services were provided to 14,207 teens (female and male ages 19 and younger). The clinical services include providing a contraceptive method and/or a clinical exam visit. The services are provided statewide at over 120 sites in Public Health Offices (PHOs), Primary Care Clinics & School-Based Health Centers. The clinical exam visit includes: a medical history/physical, family planning counseling, pregnancy testing (if needed), laboratory tests (as needed), testing and counseling for STIs, and dispensing supplies of a contraceptive method of choice. This comprehensive health screening may include mental health and drug abuse risk assessment.

The three long-term program impacts of NM DOH FPP are to reduce teen pregnancy, reduce unintended pregnancy and reduce chlamydial infections among young women. NM DOH FPP works to impact these health outcomes by promoting and providing comprehensive family planning services, including clinic-based, community education and outreach services, to promote health and reproductive responsibility. In order to uphold standard for delivery of care, NM DOH FPP evaluates program and management practices.

NM DOH FPP has met the long term impact goal of reducing the teen birth rate among young women aged 15-17 by 1% annually.

It is difficult to say with certainty what contributed to the decline in the NM birth rate, but there has been an increase in programming in NM in Doña Ana County and an increase in service learning with the Teen Outreach Program (TOP) statewide. In 2007 and 2008, the teen birth rate decreased in the most populous counties (Bernalillo, Doña Ana, McKinley, Santa Fe, Sandoval and Valencia). Also, the South Valley Male Involvement Project in Albuquerque has provided education using the Wise Guys curriculum at middle and high school sites and promotes services and refers clients to the male reproductive health clinical services offered at PHOs since 2003. By partnering with community based health providers, SVMIP and PHO staff provide needed services such as STI and HIV prevention education, counseling, and testing.

Since 2006, based on national evidence-based research, NM DOH FPP and New Mexico Teen Pregnancy Coalition (NMTPC) have recommended and utilized five strategies to prevent teen pregnancy. These strategies are:
Family Planning Services offering access to confidential, comprehensive reproductive health services including clinic-based services and community education and outreach, to promote health and reproductive responsibility.
Comprehensive sex education that teaches about abstinence as the best method for avoiding STIs and unintended pregnancy, but also teaches about condoms, contraception, interpersonal and communication skills to help young people make responsible decisions about reproductive health.
Service learning programs that include community based volunteer service and curriculum guided discussions and activities.
Adult-teen communication programs such as Plain Talk to give adults information and skills to communicate effectively with young people about reducing risky sexual behavior.
Male involvement programs for prevention efforts that specifically target boys and young men through hard-to-reach and/or vulnerable populations, such as adolescents, the incarcerated and people with limited English proficiency.

NM DOH FPP funds and monitors evidence-based education programs at 19 sites in 10 counties. The main focus of this school and community-based programming is TOP at 17 sites in 10 counties. NM DOH FPP has been working with TOP since 2004. In 2007, when state funding started to be available for teen pregnancy prevention programming, the decision was made to focus on TOP because of service learning component and the success of the program at a school in northern NM. Of the 715 teens participating in evidence-based adolescent pregnancy prevention programming annually, the majority (585) is in TOP.

III. B. 5. Children's Medical Services

The New Mexico Title V program for Children and Youth with Special Health Care Needs (CYSHCN) is titled the Children's Medical Services (CMS) that collaborates with partners statewide. With limited resources, CMS has maximized its capacity to ensure an effective system of statewide services to CYSHCN.

State Program Collaboration: CMS collaborates with Oregon State Public Health Laboratory and UNM Metabolic Consultants in the provision of Newborn Genetic Screening. CMS works with the School for the Deaf, STEP HI Program for newborn hearing screening and follow-up; UNM

Hospital OB GYN Department and several peri natologists in Albuquerque for the Birth Defects Registry and Neural Tube Defect surveillance. CMS also collaborates with the Health Systems Bureau for networking with the RPHCA funded centers. The NM Sickle Cell Council provides education, screening and follow-up for sickle cell and other hemoglobinopathies. CMS worked with Medicaid to reimburse midwives for expanded Newborn Genetic Screening. Medicaid and CMS work together to increase enrollment of children due to expanded eligibility requirements. CMS staff are trained in enrolling clients through presumptive eligibility and Medicaid on site application services. CMS is working with the Commission for the Deaf and Hard of Hearing and the Commission for the Blind and Visually Impaired to address unmet needs for children in these communities. CMS continues to collaborate with Medicaid, WIC, UNM, the Commission for the Blind and the Commission for the Deaf and Hard of Hearing to address needs of CYSHCN and children identified on newborn genetic screening and newborn hearing screening.

The Child Health program applied and was awarded the Project LAUNCH grant given to six states to include one tribal entity. This grant requires a multi agency team work with the Early Childhood Comprehensive Systems (ECCS) team to create a comprehensive strategic plan that all agencies can provide input and have similar goals in which to work towards. The ECCS workgroup in New Mexico also known as the Early Childhood Action Network (ECAN) has worked for several years with other state and private entities towards early childhood services and advocacy. Combining these two groups will enhance the work provided by the multi-agency team and ECAN to push early childhood issues forward.

State Program Support for Communities:
CYSHCN who are covered by CMS, Medicaid/SCHIP and private insurance can receive clinic services in multidisciplinary CMS/UNM/Presbyterian pediatric specialty outreach clinics, and care coordination by CMS social workers. Children under three with complex medical diagnoses go though the CMS Family, Infant Toddler Program (FIT) and are transitioned to CMS CYSHCN social workers at age three, assuring ongoing medical management and coordination of care. The number of CMS eligible children with high cost conditions enrolled into the New Mexico Medical Insurance pool increases yearly with an emphasis on meeting unmet orthopedic needs. CMS developed a new relationship with Presbyterian Health Services in 2008 and added 12 more asthma clinics statewide.

CMS currently provides payment for premiums and co-pays for over 200 clients enrolled in the NMMIP. The legislature approved $300,000 to be used in CMS specialty clinics in 2008. CMS was able toadd 10 more asthma clinics statewide and enrolled 50 clients onto NMMIP. In2009-2010 CMS enrolled 53 more clients onto NMMIP and increased the number of asthma clinics to 33 total, despite severe budget cuts to the CMS program.

Coordination with Health Components of Community Based Systems: CMS's network of 45 social workers is located and co-located with other health services in NM. CMS has experienced a statewide vacancy rate of 30% over the past several years due to budget issues and a statewide hiring freeze. The program had 60 social workers when fully staffed. They coordinate health care for CMS CYSHCN statewide. CMS works with community councils and services with the Title XVIII Medicaid and Title XXI SCHIP program, the largest providers of medical care, in an effort to provide and model family centered, community based, culturally competent coordinated care. CMS social workers provide a statewide system of oversight and care coordination for infants identified through the Newborn Genetic Screening and Newborn Hearing Screening state mandated programs, ensuring that they receive a continuum of care. After initial care for the first 3 years under the CMS/ FIT, children are transferred to CYSHCN social workers to continue care coordination. In this current fiscal year 2010 CMS-FIT was not funded by DDSD and the CMS FIT Coordinator position was eliminated from the personnel rolls thus the program had to be closed. The remaining CMS FIT staff will resort to providing services to the special needs population. CMS Social Workers will continue to partner with the statewide FIT program by providing critical care coordination and social work services to the birth to three population with special needs and/or complex medical conditions.

House Bill 479 was passed in the 2005 legislation that required expanded screening for all newborns born in the state of New Mexico, from six diagnoses to 28. CMS is worked with the State Lab, Genetic Advisory Committee and Pediatric Advisory Board to strengthen the follow-up. The CMS CYSHCN Program and the State Lab Division worked together to select an outsourcing laboratory for tandem mass genetic screening. The expanded screening was implemented in January 2006.

Oregon State Public Health Lab (OSPHL) was selected to provide testing and follow-up for the Newborn Screening program. Oregon provides short term and long term follow-up with their genetic and metabolic experts directly to Primary Care Providers (PCPs) who are caring for newborns with presumptive or confirmed screens. OSPHL coordinates with UNM Metabolic specialists after diagnosis.In January 2010 the NM Legislature passed House bill 201, mandating that five new conditions be added to the Newborn Screening. The conditions, which are all lysosomal storage disorders, will be added when testing is available and feasible as determined by the New Mexico Secretary of Health.

Coordination of Health Services with Other Services at Community Level: Healthy Transition New Mexico is coordinated through the Healthy Transition Coordinating Council with representatives from DVR, Medicaid, and Salud!, CMS, UNM LEND Program, UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, and Statewide Transition Initiative Participants to address medical and psychosocial issues of adolescent YSHCN transition. The Health Transition New Mexico Coordinating Council joined forces with the Statewide Transition Coordinating Council in order to avoid duplicating efforts. This new Council is represented by numerous State, public and private entities and shares information and collaboration on projects affecting youth in transition.

A grant proposal was submitted to HRSA/MCH in 2007and in 2009. It included the creation of a statewide council for integrated services for CYSHCN. This proposal addressed all CYSHCN goals in an integrated fashion. Experts were identified as key participants to address the medical home with experts including Trish Thomas from Family Voices, Dr. Javier Aceves from Young Children's Health Center, Sally Van Curen from Parents Reaching Out. Dr. Nelson, medical director for Presbyterian Salud! and the Navajo Nation.
CMS was not awarded the HRSA funding. However, the Navajo Nation was awarded and is collaborating with CMS to address Youth Transition.
However CMS continues to work on transition issues and developed a model multi-cultural, bi-lingual transition plan that is used in all the health offices with youth once they reach the age of 14.

Other agencies and community partners include: CYFD/child protective services, Food Stamps, ISD, community organizations providing services to multicultural and immigrant populations, i.e. Somos Un Pueblo Unido, local and statewide family organizations, school systems, some faith based service organizations such as Catholic Charities, and community domestic violence and substance abuse coalitions. Agencies and programs receiving Title V Maternal and Child Health Funding participate in a MCH Collaborative addressing transition, Medical Home and other MCH initiatives. CMS is represented on the Family to Family Health Advisory Board with Parents Reaching Out (PRO). The Newborn Hearing (NBH) Coordinator participates on the Deaf/Hard of Hearing (D/HH) Task force at New Mexico School for the Deaf (NMSD) to address unmet needs of D/HH children in their communities. Task force members include NMSD, parents; Commission for D/HH, PED, and local school districts. The CMS Medical Director participates on Multi-Agency Task Force on Early Childhood services in NM

The licensed social workers in CMS are required by statute to engage in eight hours of cultural competence training annually to renew their licenses. The care coordination in CMS is done primarily by social workers, with 2 positions filled by nurses. CMS, located regionally in the health offices decided in past years to learn and address cultural competency regionally. Working with

Hispanic communities of different origins and arrival in New Mexico, pueblos and the Navajo Nation, each region develops its own plan to carry out cultural competence training and delivery of services. While the Public Health Division under which falls the CMS Program focuses on translation for services and has allocated funding reimbursement of bilingual, bicultural staff, each region has its own issues and its own plan to assure clients receive culturally and linguistically competent care. These plans are the following:

Region 1/3 (metropolitan Albuquerque area and the Northwestern Region) Cultural and Linguistic Access Services (CLAS) Committee was created in 1998 through the efforts of Dr. Maria Goldstein Regional Health Officer (retired), Alicia Williams, CMS Program Manager and Lorenzo Garcia, Health Promotion Specialist Program Manager to address issues of cultural competency, linguistic access and health disparities. The CLAS committee is a multidisciplinary team of Public Health professionals that include a Children's Medical Services Social Worker, a Health Promotion Specialist Program Manager, a WIC Nutritionist Supervisor, the Regional Health Officer, a Director of Nursing, other nurses, and clerks from throughout Region 1/3. Activities have included: removing barriers to access of public health services for limited English proficient individuals by facilitating the training of Public Health Staff as bilingual interpreters, educating Public Health staff on how to access interpreters and cultural sensitivity presentations at the Region 1/3 meetings.

While CMS works primarily with children diagnosed with chronic medical conditions, we have discovered that we cannot look at the issue of special healthcare needs in a vacuum. Alicia Williams, Region 1/3 Program Manager for CMS, works with Native American Tribes throughout the State of New Mexico on case reviews and service planning for high- risk Native American adolescents.

Arthur Fuldauer, Family Infant Toddler Social Worker, provides outreach visits to Santo Domingo and San Felipe Pueblos. Arthur performs developmental evaluations and refers eligible children to early intervention services. Formation of Region 3 Diversity Committee was formed with the following goals in mind: Support staff in the area of diversity, support our clients, learn from other cultures on how to provide better services to our clients, listen to what the children we serve are saying as they are letting us know we have a lot of work to do, explore what we can do to support a diverse work force.

In Region 2 (Santa Fe and the Northeastern part of the state) the CMS Cultural Competency Process includes a branch of IMPART Group (Increasing Minority Participation Task Group), has worked on the development and implementation of an Intercultural Communication Training Module. Additionally, Region 2 CMS Cultural Competency committee meet on a monthly basis with a focus on: increasing cultural awareness through planned trainings and cultural learning experiences; sharing resources and advocacy for immigrant communities and increasing outreach and collaboration with Indian Health Services and Pueblo communities especially increasing competency linguistic access. A Region 2 CMS Social Worker serves as board member of the Immigrant Task Force and provides information and updates for the District 2 CMS team regarding legislation and opportunities for the immigrant population served. Region 2 CMS social workers provide service coordination and access to pediatric specialty outreach clinics for children and youth with special health care needs for all Pueblos and Native American's living within the Northeast Region of the state. Social Worker(s) in the Santa Fe office cover San Felipe, Santo Domingo, Cochiti, Pojoaque, Nambe and Tesuque. CMS Social Workers out of the Espanola office covering San Ildefonso, Santa Clara, San Juan. In Taos, one CMS social worker covers Taos Pueblo and Picuris. The Region 2 CMS staff nutritionist provides training in specialized diets for Pueblo schools and Indian School food service for children and teens with chronic illness (i.e.: diabetes). The CMS staff Nutritionist also provides nutritional counseling for Native American families of children with Special Health Care Needs. Ms. Belanger provides medical social work services to Dr.Anne Kusava at her Santo Domingo monthly (children's) chronic disease clinic. Since Dr. Kusava became chief of staff at the Indian Hospital here in Santa Fe, Ms. Belanger meets twice monthly with the physicians to identify children and youth

with special health care needs who need service coordination. The physicians reported that they needed a medical social worker to assist families, especially for newborns who are identified as being at risk, and/or diagnosed with conditions thus CMS is a point of entry for all newborns identified as being at risk and/or diagnosed with a condition. The service coordination offered by CMS entails coordination of health, medical and other community resources in order to develop and reach child and family goals. The staff of Region 2 is bilingual and bicultural in every office.

Region 4 (the Southeastern part of the state) requires eight hours of cultural training where one or two hours must be related to medical beliefs in a different culture such as the Deaf culture. The training must be approved by the supervisor. This region's quarterly meetings schedule a cultural learning opportunity such as immigration issues. There is a Mennonite Mexican population in this region, where medical needs and beliefs regarding illness and disability, are different then the mainstream This population speaks Mexican and German and the families work in the dairies and farms. They continue to try and recruit bilingual social workers as much as possible.

Region 5 (the Southwestern part of the state on the border with Mexico) will continue to maintain a bilingual bicultural staff at the existing 90%; and cultural competence continuing education for social workers. CMS experienced need, particularly during Cleft Palate Clinic, for medical interpreters. Several CMS staff completed a medical interpreter's training and receive ongoing training in this specialized area.

The Title V CYSHCN Director continues to be a resource nationally to other programs seeking Cultural Competence consultation. Susan Chacon, the NBHS Coordinator was selected in 2005 to Chair the CDC sponsored EHDI Diversity Committee which meets monthly by conference call to address issues of access to EHDI services for minority and underrepresented populations. The committee consists of representation by state EHDI coordinators, University faculty, CDC, and Indian Health Services. The Committee has developed guidelines and recommendations to programs to assist in the provision of culturally competent care for minorities and underrepresented populations who are in need of EDHI services, including the development of a culturally and linguistically competent handbook for Spanish-speaking families. This material will also be available for University staff and can be used in curriculum when training the next generation of EHDI professionals. Ms. Chacon and representatives of the EHDI Diversity Committee present on outreach to diverse families for EHDI services at national conferences. Ms. Chacon was also selected by the National Center for Cultural Competence at Georgetown University to represent New Mexico in a "Community of Learners" to improve services to culturally and linguistically diverse families who have a child with special health care needs.

C. Organizational Structure

The current administration of Governor Bill Richardson consists of 22 State Departments, including the Department of Health. Cabinet members serve at the Governor's discretion and together form a constructive advisory board in assisting the Governor in running the affairs of state, with reporting duties based on their respective agencies. Currently, the Governor's Cabinet is comprised of Secretaries and Directors of nearly thirty agencies each of who deal with particular issues the Governor deems as an important part of the overall health of our state and its people.

The New Mexico Children's Cabinet was created by Executive Order and Governor Richardson appointed Lt. Governor Diane Denish, chairperson. She indicated that early childhood issues would be her top priority. Because the goals of the Maternal and Child Health Bureau/Early Childhood Comprehensive Systems (MCHB/ECCS) grant and Children's Cabinet were aligned, it was decided that the Lt. Governor would convene a group of early childhood stakeholders and experts to develop a comprehensive long term Early Childhood Agenda for New Mexico's young children and their families from birth to age 5. The role of this group is to implement the goals of the MCHB grant and to advise the Children's Cabinet. The Cabinet Secretaries from the

Department of Health, Human Services Department, Children, Youth & Families, and the Aging and Long Term Care Departments also meet once a week to discuss issues that effect their departments and to address State Health and Human Services Initiatives. These four initiatives include the Statewide Comprehensive Health Plan, the Behavioral Health Plan, the Long Term Care Plan for Seniors & Individuals with Disabilities and the Medicaid System Redesign.

The Secretary of the Department of Health, Alfredo Vigil, MD, is a Cabinet Secretary and reports directly to the Governor. The three Deputy Secretaries are Jessica Sutin, responsible for Programs, Duffy Rodriguez, responsible for Administrative functions and
Katrina Hotrum is responsible for facilities management of 5 hospitals and healthcare centers.

The Secretary's Office houses the Public Information Officer, Chief Medical Officer, Chief Information Officer and the Chief Privacy Officer (HIPAA and related functions), as well as the Office of General Counsel. The Deputy Secretary of Programs oversees three major divisions which include: Public Health Division, Developmental Disabilities Support Services Division, and Health Certification, Licensing & Oversight the Office of Policy and Multicultural Health.

The NM Department of Health (DOH) is a statewide agency organized into 5 Regions with each of the 53 local health offices as a state agency entity.

Previous versions of the Department of Health's strategic plan aligned activities and strategies by Department program areas or division. This format limited cross-divisional thinking and collaboration. This year, the Department of Health's strategic plan has been reorganized to reflect a new framework that promotes new opportunities to think and work across divisions and better collaborate to implement innovative strategies that will improve individual health, community health and the health system. The DOH Strategic Plan has been revised to address issues in 3 Different Goal Areas: The Goals are: Goal 1:. Improving Individual Health, Goal 2: Improving Community Health; and Goal 3: Improving the Health System

Goal 1: Individual Objective 1: Increase immunizations for all New Mexicans, especially children and adolescents. Individual Objective 2: Reduce teen pregnancy. Individual Objective 3: Reduce obesity and diabetes in all populations, specifically children and adolescents. Individual Objective 4: Reduce suicide among all population groups, especially youth. Individual Objective 5: Ensure quality developmental disabilities services and improved outcomes for New Mexicans with developmental disabilities.

Goal 2: Community Objective 1: Reduce health disparities in New Mexico. Community Objective 2: Prevent and control chronic diseases. Community Objective 3: Reduce obesity and diabetes. Community Objective 4 Reduce intentional and unintentional injury. Community Objective 5: Ensure preparedness for health emergencies, including pandemic influenza. Community Objective 6: Indentify and reduce environmental exposures which adversely impact public health.

Goal 3: System Objective 1: Improve accountability and responsiveness of our services within the Department of Health. System Objective 2: Expand health care for school-age children and youth through school-based health services. System Objective 3: Create an oral health system that provides children, low-income rural populations and people with developmental disabilities with preventive and restorative oral health services. System Objective 4: Improve emergency medical services and the trauma care system across the state. System Objective 5: Improve the scientific laboratory's ability to provide laboratory analytical services to state programs. System Objective 6: Improve resident care services in Department of Health facilities. System Objective 7: Eliminate abuse, neglect or exploitation of seniors and vulnerable adults. System Objective 8: Increase the number of state licensed providers who receive a regular and periodic review of provider compliance. System Objective 9: Improve recruitment, retention and training of health care providers in rural, American Indian and border communities. System Objective10: Increase use of technologies to improve health outcomes.

The Department of Health understands that communities are the center of health care. Thirty-seven local health councils are maintained by the department to gather feedback and recommendations. This allows for modification of services and programs to meet the needs of individual communities. By focusing on community health, the Department will reduce health disparities, the transmission of infectious diseases, and exposure to environmental dangers that can be detrimental to health. DOH will also ensure that communities are prepared to address any health emergency that may arise.

The Public Health Division (PHD) Director is Jack Callaghan, PhD. The PHD Director's Office includes two Deputy Directors.

The Public Health Division (PHD) consists of 5 Region Offices, an Office of Border Health, a Pharmacy Office, and 5 Bureaus: Program Support, Health Systems, Chronic Disease, Infectious Disease, and Family Health. The Family Health Bureau is the largest bureau in the Public Health Division. The Family Health Bureau Chief is Emelda Martinez.

The Family Health Bureau (FHB) is located in the Colgate Building at 2040 South Pacheco, about six blocks from the main DOH building. Organizational charts for the Family Health Bureau and the Public Health Division of the Department of Health are in the Appendices. Maternal and Child Health is managed by Carol Tyrrell. Susan Lovett is manager of the Family Planning. Family Food and Nutrition (WIC) Program director is Deanna Torres.

The FHB is organized into five programs: 1. MCH Epidemiology, 2. Family Planning, 3. Children's Medical Services, 4. Family Food and Nutrition and, 5. Maternal and Child Health. The FHB is responsible for carrying out all but two of the Title V programs. The Adolescent Health Program and the Child Safety Program are located within other DOH divisions.

The Adolescent Health Program is housed within the Health Systems Bureau in the Public Health Division (PHD.) The Child Safety Program has been located in the Injury Prevention and Emergency Services Bureau for several years and recently moved to the Office of School Health, the Adolescent Health Program Manager reports directly to the PHD Deputy Division Director. The Division felt Adolescent Health belonged within that Office due the Governor's initiative to better fund the Office of School Health by providing 34 new school based health centers and to involve youth in policy making for those centers.

Those programs with allotments under the Title V Program are: Children's Medical Services for Children with Special Health Care Needs, the Maternal Health Program, the Child Health Program, the Child Safety Program, Adolescent Health and the MCH Epidemiology Program. Other partner programs administered within the same bureau are: the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the WIC Farmer's Market Nutrition Program, the Commodity Supplemental Food Program, the Title X Family Planning Program, the state sponsored Families FIRST Perinatal Case Management Program.
The Dental Program continues to be in the Health Systems Bureau, with easy access to the FHB/Title V MCH Agency for consultations on oral health in mothers and children.

The administration of Governor Richardson has benefited the Title V Program due to its focus on children's issues. Due to a current hiring freeze and budget constraints personnel processes and contracting processes are still very inefficient although great effort has been exerted to try to shorten the processes. Many administrative changes took place based upon an analysis done of DOH by a private consultant. However, due to the economic environment many of the processes have been put on hold.

Maternal, Child Health Program (MCH) consists of the Maternal Health Section Manager, the Child Health Program Manager, the Maternal Health Program Manager, a Child Health Consultant and support staff. This small staff obtained the ECCS and Project LAUNCH grants. These grants have provided a unique opportunity to bring together public and private partners to

form The Early Childhood Action Network (ECAN) a statewide network of over 300 early childhood champions dedicated to improving the health and well-being of young children in New Mexico by raising awareness of policy makers as well as business leaders, families, educators, early childhood providers, health workers, and community members. The MCH Section, also includes the Families FIRST Program, a state funded perinatal and child case management program, which works very well within the context of the MCH Section and strengthens its ties to daily direct services.

The MCH Epidemiology Program in the Family Health Bureau has been modified to better serve the data and information needs of the FHB and its many partners. It has incorporated the resources that support data, surveillance and epidemiology for child health needs such as birth defects, newborn hearing screening. Analysis of the CYSHCN survey and NSCH is also performed within this group. The MCH Epidemiologist currently utilized to aid in the data collection and evaluation of MCH data, position funded by SSDI, to work on Title V MCH specific data and assessment tasks. This will include assistance with the development of state plan to assess childhood obesity and underweight; coordination of comprehensive assessments; the MCH Block Grant and analysis of WIC data for selected priority topics.

The organizational Structure of the FHB remains essentially the same. The Bureau is constantly evolving and working to continue to meet the needs of the people of New Mexico despite the staffing shortages and budget shortfalls.

FHB-PHD Organizational Changes Information Technology Consolidation: The Governor's Executive order to consolidate all information technology (IT) operations in State Government has greatly impacted IT and program operations All IT functions and staff were consolidated within cabinet and executive agencies and now report to the agency Chief Information Officer (CIO) of that agency. The Governor's Chief Information Officer control and manage of all IT expenses within the agency, either by the establishment of an independent IT organizational budget or by the establishment of administrative financial controls of IT expenses within existing agency budgets, subject to the approval of the Cabinet Secretary. The cabinet or executive agency CIO has approval authority over all agency IT-related spending, subject to the approval of the Cabinet Secretary. The cabinet or executive agency submits a complete inventory of agency IT hardware, software and licenses in a standardized electronic format, to the Office of the CIO by June 1.

The difficulties previously encountered with the financial accounting system are being resolved. There have been steps to assist in training needs. The Family Health Bureau (FHB) has implemented a fiscal group designed for senior fiscal staff to assist those that may be experiencing difficulty. This has proven effective. FHB also scheduled a managers training session to assist managers with the financial system, how to obtain reports, view balances, etc. This was well received and a follow up session was requested.

D. Other MCH Capacity

III. D. 1. Title V Director's Office

The Family Health Bureau houses 10 separate programs. The Bureau Chief, the Medical Director and program support staff works collaboratively as a team to use resources strategically to meet identified needs within this population depending on program focus. Bureau Chief, Emelda M. Martinez oversees all programs and works with each of the 8 program managers for direct oversight of each program. Ms Martinez has extensive MCH management and experience. As an RN she worked in the Pediatric Intensive Care Unit at St. Vincent's Hospital for 10 years. She worked with Human Services in the Medicaid Division managing the Maternal, Family Planning, EPSDT and Midwifery programs. She has worked with the Department of Health for 5 years managing the Families FIRST case management program and Maternal and Child Health programs

Dr. Elizabeth Matthews serves as the Title V Medical Director. She is a board certified pediatrician, and served as Medical Director for CYSHCN in New Mexico for the last 4 years. As a pediatrician Dr. Matthews served CYSHCN for fourteen years at the University of New Mexico.

The programs in the Bureau consist of Women Infants and Children (WIC),which includes two Farmers Market programs and the Breastfeeding program; Children's Medical Services (CMS) includes the Genetic Screening program, Newborn Hearing program and Birth Defects program; Maternal Child Health (MCH) includes the Midwifery program licensing both certified and licensed midwives, the Child Health program, Maternal Health program, High Risk Pregnancy program and the Families FIRST perinatal case management program; The Family Planning section includes the Teen Pregnancy Prevention program, Teen Outreach program and Male Involvement programs. The MCH Epidemiology section consists of two epidemiologists, a clerk and a health educator. As of June, 2010. The positions of program manager and two additional epidemiologists are vacant. It includes Pregnancy Risk Assessment Monitoring (PRAMs) and the State Systems Developmental Initiative program (SSDI), an is responsible for coordinating the Title V Block Grant application, report, and five year needs assessment. The MCH Epidemiology program is responsible for all data collection and analysis between Departments, Divisions and programs.

The Bureau administrative staff consists of Monica Montoya, Financial Administrator and Amanda Sandoval, Clerk Specialist, who provide overall Bureau program support.

III. D. 2. Maternal and Child Health, Title V Funded Staff

Carol Tyrrell, RN, is Section Manager & supervisor of 5 programs, 4 programs funded by Title V & 1 revenue driven program. She supervises 7 State office staff. Jaymi McKay, RN, LM, is the Maternal Health Manager, responsible for the High Risk Prenatal program, Midwife Licensure and Regulation & the Maternal Health program. The Child Health Manager, Gloria Bonner, is responsible for the ECCS Grant, Las Cruces Home visiting contract, & program activities that focus on child health. Health Educator, Diane Dennedy-Frank, MSW, assists with segments of the ECCS grant & the child health component of the program. She also assists the Maternal Health Program Manager with special projects. Amanda Romero, Clerk Specialist, provides office support for MCH staff. Administrator II, Rima Varela, performs budget operation processes for MCH program.

The Families FIRST Program is a revenue driven program obtaining reimbursements negotiated through Managed Care Organization (MCO) contracts & Medicaid (JPA). Maureen Burns, Program Manager, supervises 5 state staff & provides oversight of 4 Regional Coordinators, 24 Care Coordinators, & 5 Clerks. Social Worker Consultant, Laura Sullivan, MSW, develops needs assessments, training to address needs & improve services to clients, & quality assurance. Marilyn Pearson, Registered Nurse Consultant, provides programmatic direction to 4 Regional Coordinators. She also monitors the Families FIRST Provider network & provides oversight of quality improvement for the perinatal case management population. Care Coordinators provide care coordination for pregnant women & children, assist clients with Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) & the MCO process. They also assist with establishing medical homes, community resources & referral networks. Families FIRST Care Coordinators are located in 23 sites throughout the state. Lorraine De Vargas, Management Analyst, maintains financial processes & budget operations. Jessica Marquez, Medical Secretary, maintains client & claim-processing databases. Rita Carmen Herrera, Clerk Specialist, provides clerical support for Families FIRST staff.

III. D. 3. Children's Medical Services

Lynn Christiansen, LMSW served as the Title V Children and Youth with Special Health Care Needs (CYSHCN) Director from 1999 until her retirement in April, 20l0. A request to post the

position to hire her replacement has been submitted. During this time, Ms. Susan Chacon, LISW has been selected to serve as the Interim Title V CYSHCN Director. Ms. Chacon has 10 years of program management within the Maternal and Child Health Program. . Ms. Chacon has been working with the CYSHCN program manager for many years The Title V CYSHCN Director position is the Statewide Program Manager for Children's Medical Services, under which fall the CYSHCN Program, The Multidisciplinary Specialty Outreach Clinic Program; the Newborn Genetic Screening Program; the Newborn Hearing Screening Program, the CMS Family Infant Toddler Program and the Healthier Kids Fund Program.

CMS hired a new Medical Director in 2008, Dr. Janis Gonzales who is a pediatrician with many years of experience working with CYSHCN. Dr. Gonzales is Board Certified in Pediatrics and in Hospice and Palliative Medicine, and has a Masters Degree in Public Health. She previously spent 9 years in private practice and then worked in hospice and in Early Childhood Developmental Screening before joining CMS. She also had a daughter with special needs. Dr. Gonzales serves as the AAP Chapter Champion for the EHDI program and works closely with the newborn hearing screening coordinator.

CMS has 68 staff in 29 field offices throughout the state along with 10 state office staff for a total of 78 staff presently. All staff are involved in the Title V CYSHCN programs. With a former staff of 120 statewide, this highlights the considerable vacancy rate that has been shouldered by remaining staff. The workload has not diminished, and has, in fact continued to increase in direct service, administrative and fiscal responsibilities. The staff capacity is down 31% in the last decade. Social workers, Supervisors, and Program Managers alike are covering vacant caseloads, traveling long distances to try to assure coverage to CYSHCN statewide. In addition, the program was recently given the administrative task of annual renewal of 700 providers while the Business Operations Specialist and the CMS Financial Manager Positions are vacant. The request to hire has been approved to fill 4 Social Worker positions and 1 Social Worker Supervisor position -- these hires are in process. Five additional field social worker positions are becoming vacant this year and will remain so indefinitely.

Region 1
2 Social Workers

Region 3
1 Program Manager
1 Social Worker Supervisor
5 Social Workers

2 Vacant Social Worker positions

Region 2
1 Program Manager 1
2 Social Worker Supervisors
6 Social Workers
1 Nutritionist
5 Clerks
1.5 Dental Case Managers

This region has lost 2 Social Worker positions this Spring, with the planned retirement of another Social Worker Supervisor and a Social Worker by Fall, 2010.

Region 4
1 Program Manager
2 Social Worker Supervisors
7 Social Workers
3 Client Service Agents

6 Clerks

There are 3 vacant social work positions.

Region 5
2 Social Worker Supervisors
11 Social Workers
1 Nutritionist
9 Clerks

There are 3 vacant Social Worker positions and the Program Manager position is also vacant.

The CMS State Office is down five crucial positions of fifteen total assigned to State Office. Vacant are: the Title V CYSHCN Director, the CMS Financial Manager, the Health Educator in charge of NMMIP/Youth Transition, the Business Operations Specialist/Clinic Coordinator, and the Family Infant Toddler Program Coordinator. The last three positions have been eliminated and will not be filled. The Financial Manager is in the process of being hired. The CMS program was unable to hire social workers for several years due to retention and recruitment issues and more recently the addition of a statewide hiring freeze initiated in 2008.

The FIT Coordinator resigned her position in 2009 and this position was recently eliminated by DOH. Two FIT social worker positions in Region 4 have remained vacant for several years and there are 2 FIT social workers retiring in Region 2 in 2010. It has been decided by the Public Health Division and the Developmental Disabilities Division that it is no longer feasible to continue the CMS-FIT program. The CMS FIT social workers will become CYSHCN social workers and the clients receiving service coordination will be transitioned to other EI agencies.

The state office staff consists of the Title V Statewide CYSHCN Program Manager, the CMS Medical Director, two nurse consultants who work with Newborn Genetic Screening, a Newborn Hearing Screening Coordinator whose position is funded by a HRSA/MCHB grant, a clinic coordinator, a financial specialist, a training and development specialist and clerical staff. The CMS management team includes the statewide Title V CYSHCN program manager, the medical director, the field supervisors, regional program managers and key state office staff. The management team meets monthly to review policy issues related to the implementation of the CMS programs.

The Birth Defects Prevention and Surveillance System is maintained by the Office of Epidemiology in the DOH. The data is being housed in the Newborn Screening Tracking system which integrates data for newborn hearing, newborn genetic screening and birth defects.

Working within the program are at least two parents who have children with special health care needs, and others who were children/youth with special health care needs or had sisters or brothers with special needs. In addition, the Title V CYSHCN program contracts with Educating Parents of Indian Children and Hands and Voices to provide support and training of parents. In this way, the program has internal and external family expertise.

The CMS CYSHCN management team participates in the planning and evaluation of the delivery of services to CYSHCN. With a Statewide Program Manager who is a social worker and four District Program Managers who are also required to be social workers, as well as 12 Social Work Supervisors, the 44 social workers in the CYSHCN program receive ongoing supervision and evaluation of their job performance.

The CMS program is working in collaboration with the Family Health Bureau MCH Epidemiology program to improve its data collection and analysis of the newborn screening program and other health indicators especially as reported in the 2001 SLAITS survey. Supervisors evaluate their services in an ongoing fashion, with a computer program that assists them in monitoring caseload

size. This system needs to be replaced as it is no longer viable, but a new system has yet to be determined.

III. D. 4. Maternal and Child Health Epidemiology

The Maternal and Child Health Epidemiology program coordinates the Title V Block Grant and Needs Assessment, the State Systems Development Initiative (SSDI), and the Pregnancy Risk Assessment Monitory System (PRAMS), and conducts data analysis for other programs. Currently, there are two epidemiologists, a health educator and a clerk. Eirian Coronado, MA, coordinates the PRAMS survey. Alexis Avery, PhD, MPH, coordinates the Title V grant & Needs Assessment, and is the SSDI director. There are two vacant epidemiologist positions, and the position of program manager was dissolved. Due to budget cuts and the hiring freeze, it is unknown when vacancies will be filled.

III. D. 5. The Family Planning Program (FPP):

There are 51 Family Planning Program staff in Public Health Offices throughout the state and 9 State Office staff. The field office staff consists of nurses, clinical nurse practitioners, and clerks who provide direct services to clients. The Program Manger in the State Office manages the statewide Family Planning Program including oversight of budget, personnel, Federal Grant requirements and contact with the Office of Population Affairs in Dallas and Washington, DC. The Program Manager supervises Program staff and ensures coordination of Family Planning Program activities with the Family Health Bureau, the Public Health Division and the Department of Health.

E. State Agency Coordination

III. E. 1. Office of Title V Director

The Title V Director, Emelda Martinez, is the Project Director of the Early Childhood Comprehensive Systems (ECCS) Grant. This grant's advisory board, the Early Childhood Action Network (ECAN) is a collaborative of state agencies listed in III E 1 for Project LAUNCH, & also includes public/private partnerships. The public/private partnerships include: UNM Family Development Center, The Center for Developmental Disabilities (CDD), & The NM Pediatric Society.

The MCH programs enhance the capacity of the Title V program through UNM Family Development Center, the NM Pediatric Society, The Center for Developmental Disability, and the County Health Councils. We share available technical resources, data, training, and educational programs.

III. E. 2. Maternal & Child Health

Project LAUNCH, a SAMHSA grant, required the formation of a multi-agency team (MAT) consisting of State managers from Human Services Depart. (HSD), Public Education Dept. (PED), Children Youth & Families Dept. (CYFD), & Dept. of Health (DOH). MAT meets on a monthly basis as a collaborative council to support the New Mexico Project LAUNCH initiatives. These same agencies, as well as public/private partnerships, also work in collaboration to support the Early Childhood Comprehensive Systems (ECCS) grant.

The 2009 ECCS Grant supported the hiring of an Early Childhood Coordinator (ECC). The purpose of this position is to align and coordinate all state-level early childhood programs and services to create an effective and efficient structural, functional, and operational system to offer early childhood services for children, birth through eight and their families.

The ECC position is being housed within the Office of the Secretary of the New Mexico Department of Health and will report directly to the Deputy Cabinet Secretary. The ECC is working with the Child & Youth Policy Advisory in the Office of the Lieutenant Governor and will have the authority to work across agencies to discuss and develop implementation of the strategic plan recommendations outlined in the ECCS grant and the 2009-2012 New Mexico Early Childhood Comprehensive State Systems Strategic Plan. The ECC will also work directly with the Secretaries of Health, Public Education, Human Services, and Children, Youth and Families as members of the Children's Cabinet, as well as other agency groups and public/private partnerships, to accomplish the goals of the Strategic Plan.

Pregnancy Care

Federally qualified health centers and primary care association(s): At the state level, the Community Health Systems Bureau oversees the primary care program, administering grants of state money and regularly communicating with each center and association, as well as the New Mexico Primary Care Association. FHB managers are meeting on an ongoing basis with the leadership of the Health Systems Bureau to study access to prenatal care statewide and to strategize how to increase access. University of New Mexico (UNM): DOH prenatal care clinics all refer high-risk patients to primary care or private providers, or UNM Health Sciences Center (HSC). All of these are under agreements with the Maternal Health Program to provide appropriate high risk care. UNM HSC is also under contract to provide low-risk care to 431 medically indigent Albuquerque residents. Maternal Health collaborates with UNM HSC to improve safety-net prenatal services statewide. Tertiary care facilities: Tertiary Care Facilities are so determined by specialty services and capacity. In NM there are two "level III perinatal facilities" with maternal-fetal specialists, neonatal specialists, and facilities to provide specialty care. These are: University of New Mexico Hospital and Presbyterian Hospital, both located in Albuquerque. They have a joint transport system to transport women in pre-term labor from around the state.

III. E. 3. Family Planning Program

In order to reach clients statewide, Family Planning Program (FPP) contracts with Primary Health Care organizations. FPP provides monetary compensation in the form of fee for family planning services and by providing contraceptives, medications to treat STIs, prenatal vitamins, and laboratory testing such as Pap, syphilis, chlamydia and gonorrhea testing. The Primary Health Care clinics provide low/no cost services, which include some preventive and counseling services. This collaboration is crucial to clients' access to family planning services in a rural state like NM where clients may have to travel over 30 miles to the nearest Public Health Office.

FPP has a collaborative relationship within the STD Program for the management of the CDC Regional Infertility Prevention Project for decreasing Chlamydia infection in young women. FPP works with the NM Human Services Department Medical Assistance Division which oversees the NM Family Planning Waiver Program on projects such as the Emergency Contraception Pill Public Media Campaign.

FPP and New Mexico Teen Pregnancy Coalition (NMTPC) collaborate to reduce teen pregnancy with Plain Talk and the Teen Outreach Program (TOP). The Plain Talk program is a community-based initiative proven to help adults develop skills to communicate effectively with teens about reducing sexual risk taking. Plain Talk and TOP are offered in Doña Ana County and Albuquerque. FPP and NMTPC issued Challenge 2010, to reduce teen birth rates for teens from 2006-2010 by 15%. Several counties are meeting the goal of the average birth rate (2006-2008) being at least 15% lower than the baseline birth rate (the average birth rate from 2001 to 2003). Four counties have reached or exceeded the goal for both 15-17 and 15-19 year olds and three counties have reached or exceeded the goal for 15-19 year olds. Two counties reached or exceeded the goal for 15-17 year olds, including Bernalillo County, the county with the highest population in NM. Three other counties are very close to the goal, including Doña Ana County,

which in 2006 had its first reduction in birth rates since 1998.

III. E. 4. Children's Medical Services

Both UNM and Presbyterian hospitals provide pediatric sub-specialists for 130 DOH Children's Medical Services (CMS) multidisciplinary outreach clinics throughout the state. Clinics provided include asthma, cleft palate, neurology, metabolic, endocrine, genetics and nephrology. Providing services and multidisciplinary clinics statewide, the CMS Program connects with over 700 medical providers, community social service agencies, state agencies and hospitals. These relationships form the basis for critical care coordination that the CMS social workers provide for CYSHCN clients statewide.

CMS works closely with Families First, the WIC Program, and the Title V Child Health Unit as well as all of the State's Human Services Agencies. CMS social workers assess insurance options for clients and assist clients in applying for Medicaid and S-CHIP. The CMS Family Infant Toddler (FIT) program now requires mandatory insurance screening on all clients enrolled in the program. Additional FIT providers have being trained in PE/MOSAA.

CMS-FIT staff works with Children Youth and Families (CYFD) to implement the requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA) where children birth to three years of age with a substantiated case of abuse or neglect must be referred to early intervention (EI). The CMS Medical Director participates in the New Mexico Interagency Coordinating Council (ICC) which is the advisory body to the FIT program. The Council is made up of representatives from Medicaid, CYFD, Public Education Department, Public Insurance Commission, the NM Pediatric society, local EI providers, UNM and families.

The CMS Medical Director represents CMS on the Multi-Agency Team which advises Project LAUNCH, a project designed to increase quality in all early childhood service areas. Other team members include representatives from United Way, NM Public Education Department, the Developmental Disability Services Division, the Injury Prevention Program, the NM Hospital Association, the Children, Youth and Families Department, and the Human Services Division (Medicaid).

CMS is represented on the Family to Family Health Advisory Board with PRO, the MCOs and Medicaid. The Newborn Hearing (NBH) Coordinator participates on the Deaf/Hard of Hearing (D/HH) Task force at New Mexico School for the Deaf (NMSD) to address unmet needs of D/HH children in their communities. Task force members include NMSD, parents, Commission for D/HH, The Public Education Department (PED), and local school districts. She is also a board member of Hands and Voices, a parent organization that supports families who have children that are deaf or hard of hearing. The NBH Coordinator also is the chair of the CDC sponsored Diversity Committee which includes federal agencies, state health departments, University faculty, families and those working on improving access to care for minority children who are deaf or hard of hearing.

With the Governors' Insure New Mexico Initiative, coverage has expanded regarding 0-5 programs and youth above age 19 programs for Medicaid-like program for non-Medicaid children and youth. The State Coverage Initiative Program was instituted in FY05 for employers with less than 50 employees. This program requires a minimal payment by both the employer and the employee and provides comprehensive health coverage. Funding varies and currently this program is closed to new enrollment. CMS has been a participant in the Medicaid Outreach Committee, which is actively working to enroll children onto the various Medicaid programs. There are several gaps in coverage in several of the Medicaid programs including lack of coverage for dental, vision and mental health services.

In partnership with the Health Systems Bureau and the Office of Oral Health, Region 2 CMS/OOH Social Workers (2) have provided case management and follow-up to improve access to

preventative and restorative dental services. The CMS/OOH social workers have provided dental case management services to a total of approximately 500 clients/families per year in Santa Fe and Rio Arriba counties. The dental case management has involved collaboration with numerous agencies, programs and dental offices within the community. In addition to the case management services, there is coordination of Flouride Varnish Clinics for approximately 650 children (per year) who attend Head Start/Pre-K programs in the 2 counties. The screening at these clinics has identified approximately 200 children/families who are provided case management services. The SF Dental Case Manager assists with elementary school based sealant clinics and provides case management services to approximately 300 children/families screened and referred at these clinics. The CMS/OOH Social Workers place a strong emphasis on parent education as well through the various other components of the Oral Health Program. Family education about good oral hygiene and proper nutrition provided has proven very successful in regard to outcomes. Additionally, the CMS/OOH Social Worker in partnership with Community Dental Services have coordinated between 3-10 weeks (per year) of free adult basic dental care clinics in several counties of Region 2 .

CMS participates on the New Mexico Statewide Transition Coordinating Council (STCC) along with the NM Public Education Department (Special Education Bureau), Division of Vocational Rehabilitation (DVR), the ARC of New Mexico, Governor's Division on Disability, Albuquerque Public Schools and others. The NM STCC is designed to enhance interagency collaboration at the state level and cooperation at the local level, creating an infrastructure to develop and improve transition services.

CMS and UNM Hospital have negotiated an increase in the number of outreach clinics, but it has been difficult to provide sufficient clinics statewide due to insufficient funding and a shortage of pediatric specialists in the state. Funding through Governor Richardson's Disability Agenda for Children allowed CMS to increase the number of pulmonary clinics and contract with the Presbyterian Hospital pediatric pulmonologist. The CMS CYSHCN Program together with DOH Epidemiology initiated a series of asthma summits around the state. The summits resulted in recommendations addressing regional needs and helped develop local and state responses and interventions.

CMS contracts with Oregon State Public Health Lab to provide newborn screening in coordination with the CMS Medical Director, Nurse Manager and the nurse case manager, who work with OSPHL to assure short and long term follow-up on infants with a presumptive or confirmed positive. UNMH pediatric sub-specialists in metabolism and genetics are contracted to consult with CMS's Newborn Genetic Screening Follow-up Program.

CMS contracts with EPICS (Education of Parents of Indian Children with Special Needs) to provide leadership training to parents who have CYSHCN and will be participating in the integrated services Dine for Our Children DOC Project with the Navajo Nation with a focus on youth transition. During FY '10 and '11, the funding is provided through the supplemental funding from HRSA through the NBHS program. The contract is also being used to strengthen support and education specifically to Native American families whose children are deaf or hard of hearing. The NBHS program is also working closely with the New Mexico Speech and Hearing Association to provide training opportunities to NM audiologists around the standard of care in pediatric diagnosis of hearing loss. In a pilot project in Gallup, audiology services are being provided via telehealth. The project is in collaboration with UNM Department of Audiology, Project ECHO, Gallup Indian Medical Center, Rehoboth McKinley Christians Hospital, the New Mexico School for the Deaf and Growing in Beauty the early intervention provider on the Navajo Nation.

The MCH Collaborative was reorganized and is now comprised of CMS, Family Voices, Parents Reaching Out, the UNM Lend Program and the Developmental Disability Planning Council and a newly organized Parents of Indian Children with Special Needs (EPICS) 501 c 3 Program. All participants share the personal dedication and commitment to Title V. The rebirth of this collaborative has been supportive and innovative and is now resulting in the submission of

collaborative grants that address transition and Native American CYSHCN issues.

III E. 5. Families FIRST

The Families FIRST program provides case management services in 22 counties, contracting with the Managed Care Organizations (MCOs) provider network and public health offices to address the needs of pregnant women and children 0 to 3 years of age. Efforts have been made to increase Medicaid reimbursement rates and provide uniform services.

DOH is using Medicaid administrative billing across programs with the assistance of a contractor. Currently services may differ from MCO to MCO and from MCO to Medicaid fee for service. Both MCH and Families FIRST are members of the EPSDT Steering Committee.

Both CMS and Families FIRST work in close collaboration with all of the state's Human Services Agencies. Each program assists clients in applying for Medicaid and S-CHIP through the Medicaid On Site Application Assistance (MOSAA) and Presumptive Eligibility applications, and coordinates with the local Income Support Division (ISD) offices to assure quality client service.

III. E. 6. Oral Health

The New Mexico Department of Health was awarded a grant from the Health Resources Services Administration (HRSA) to develop an infrastructure to implement a NM Oral Health Surveillance System (OHSS). In partnership with the Health Systems Bureau and District II Santa Fe CMS program, the statewide Oral Health Surveillance System (OHSS) pilot program is providing case management to over 300 clients through a part time social worker. The OHSS collects, measures and assesses oral health conditions and disparities in women, children and families. It also improves access to preventative and restorative services. Collaboration continues with numerous agencies, programs, and dental offices within the community.

There has been significant success in promoting oral health care with our participation in community outreach events such as local health fairs, Sealant Clinics, and the CMS Cleft Palate Clinics. People are utilizing the services of the dental case manager and appear eager to learn more about proper dental care for themselves and their children. Case management has been beneficial in helping clients follow through with appointments, accessing oral health care resources (including financial), and providing important educational information about oral health care maintenance. By improving access to oral health care through case management, the expected outcome is to reduce dental caries in children and establish an effective oral health screening and referral service for children and their families.

The Dental program helps individuals and families access dental services in the community through Dental Case Management program that currently serves Santa Fe and Rio Arriba counties. This program has been very successful and the DOH PHD is looking to replicate it statewide. The program also provides oral health and educational outreach in the community, including Head Start Programs and childfind screening clinics (SF and Espanola area), oral health education and dental case management/follow-up with the Fluoride Varnish Program (for children 0-5 years of age), coordination of these clinics in partnership with SF WIC, SF and Rio Arriba Headstart programs. It participates with the Office of Oral Health's Santa Fe Public School Sealant Activities (for children in the first through third grades) in provision of oral health education and dental case management/follow-up. The program coordinates free adult dental clinics throughout Region II in partnership with the Community Dental Services and provides consultation to Region II Public Health Programs to provide enhancement of dental case management to Public Health clientele.

III. E. 7. Office of Injury Prevention

The Office of Injury Prevention (OIP) of the Dept. of Health takes the lead on all aspects of

unintentional childhood injury and has had a contract with SAFE KIDS Worldwide to be the sponsor for NM SAFE KIDS Coalition for the past 15 years. OIP and its partners provide car seat clinics, including free car seat checks and/or seat replacement, bicycle rodeos, including free helmet fitting checks and/or distribution, and health fair displays, including free smoke and carbon monoxide detector, as well as gun lock, distribution. OIP has also collaborated with the Children, Youth and Families Dept. during the past 5 years to provide home safety training for the 8,000 home daycare providers, and plans to expand the program to foster, adoptive and grandparents.

State coalition members were instrumental in the expansion of the child car seat law from age 1 to age 5.The first booster seat law in 2005 requires mandatory use for ages 5 and 6, and optional use, based on size, for ages 7 through 11. New Mexico is now the first state to require that all children under the age of 18 wear a helmet on every recreational vehicle.

Safety training and home visitation programs are being developed concurrently to serve an expanded population of first time parents. 4-6 counties will be added to the home visitation program in the coming year. As federal funds are diminished, OIP is seeking funds from other sources and permanent state funds. Safety training for home visitation programs will continue to expand. Given budget constraints, it is unknown how many additional programs and counties will be added in the coming fiscal year. The Office of Injury Prevention is actively seeking private charity and foundation funding to augment the programs.

The Network Coalition against domestic and sexual violence continues to expand its influence and function well. The award winning video entitled "Stolen Childhood" has continued to be distributed widely.

III. E. 8. WIC

WIC Program: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program safeguards the health of pregnant, breastfeeding and postpartum women, infants and children under five years of age with a household income 185% of FPL who are at nutritional risk. The WIC Program was the first in the nation to pilot a hybrid electronic benefits transfer card for WIC recipients using a cost effective model. WIC and the CMS FIT program developed a plan to increase referrals of children with special health care needs and children with or at risk for developmental delay.

Commodity Supplemental Food: This program provides supplemental nutritious food to low-income women, infants, children and seniors. USDA donates the food. New Mexico is one of the top three states in the country for food insecurity. NM has applied for more caseload from USDA and has not been granted new caseload for several years.

Farmers Market Nutrition Programs (FMNP): This program provides fresh fruits and vegetables from farmers' markets to women, infants, and children who are nutritionally at risk and who are participating in the WIC Program. Participants receive $28 in coupons to be redeemed at local Farmers' Markets.

The WIC food package has been revised to include a greater variety of healthy food choices that are culturally acceptable. The WIC foods provided to families are specially designed to provide specific nutrients to help with the growth and development. WIC Program received a $390,000 grant from USDA to reduce childhood obesity. USDA has provided New Mexico funding to serve 67,000 participants per month.

F. Health Systems Capacity Indicators

Introduction

Poverty and lack of health care coverage are the two most serious problems facing New

Mexicans. Moreover, geographic and cultural barriers, and provider shortages present major challenges to New Mexico's capacity to address health problems within the MCH population. In 2003, NM ranked 46th in per-capita personal income at $25,502, which was 81.1% of the national average. The state's poverty rate remains one of the highest in the nation. The State is among the five states with the highest rates of uninsured children. An estimated 22.5% of New Mexicans are uninsured, including 15.5% of those under age l8, compared to a national median of 9.2%. Only one of New Mexico's counties, Los Alamos, is designated by HRSA as neither "Medically Underserved," nor a "Health Professional Shortage Area (HPSA)." The remaining 32 counties are either entirely or partially underserved and are considered HPSAs. More than 700,000 people live in these areas. Disparities due to race, ethnicity, age and sex persist.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	34.0	34.0	34.0	34.0	34.0
Numerator	464	474	474	474	474
Denominator	136637	139300	139300	139300	139300
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2007, 2008 and 2009 hospital discharge data are not yet available.

Notes - 2008
2007 hospital discharge data are not yet available as of July 2009, but are expected to be available later in the summer.

Notes - 2007
2007 and 2008 Hospital Inpatient Discharge Data (HIDD) for asthma patients are not yet available.

Narrative:
The 2007 New Mexico (NM) BRFSS child current asthma prevalence rate was 8.6% (US child 9.1%, CDC). Management of asthma in NM is complicated by high poverty rates, high numbers of uninsured, high numbers of undocumented immigrants, low population density and large size. Twenty three of New Mexico's 33 counties are primary care Health Professional Shortage Areas.

Asthma hospitalization for children under 5 years of age has been increasing since 1995, increasing 37% from the 1995 level of 25.4 per 10,000 to the 2008 rate of 34.8. A 2009 surveillance report "The Burden of Asthma in New Mexico" of hospital inpatient discharge data (2000-2006) shows that the younger the child the more likely they were to be hospitalized, and the rates for under age 5 were higher than for ages 5 to 9 years. Data for infants under one year are difficult to assess because of diagnostic difficulties in that age group. For children = 15 years, White children had the lowest rates of hospitalization (14.9 per 10.000 in 2006), then Hispanic (17.3); the highest were Black children at 34.9 (2000-2006). (HID data does not include Federal Indian Health Service (IHS) hospitals so there is no comparable data for Native American

children.) Facility user data for Native American children who used Navajo Area IHS facilities show the hospitalization rate (2001-2004) was highest in the under 5 year age group, at 91.5 per 10,000 and only 15 in the 5-15 age group. NM hospitalization rates show significant regional variation: in the Southeast the rate for the = 15 age group is 58.0, 167.3% higher than the state rate (21.7). Similar patterns are found in asthma emergency room rates.

Since 1999 the NM Asthma Coalition has brought community, statewide, and national partners together to address asthma issues in the state. In 2007-08 the Children's Medical Services (CMS) Program and the State Asthma Program of the NM Department of Health (DOH) held 7 pediatric asthma summits throughout the state to present asthma data, raise awareness, to seek input and information from the community, and to network with local and state resources. A statewide initiative emerged from the summits involving the DOH, and many diverse community partners to reassess asthma care in the state, and formulate new strategies to address the issues identified in the Summits. Increased numbers of School-Based Health Centers will improve access to asthma care around the state. Project Envision NM and the UNM ECHO Program are bringing asthma education and consultation to health professionals in rural areas. The CMS program provides medical social workers statewide for asthma care coordination but budget cuts have reduced their numbers from 60 to 40. CMS contracts with UNM and Presbyterian Hospital Pediatric Pulmonary teams for 31 asthma outreach clinics throughout the State annually.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	63.5	68.1	76.8	74.4	74.4
Numerator	10927	13460	15880	16237	16237
Denominator	17218	19766	20684	21815	21815
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not yet available.

Notes - 2008
Denominator is the number or medicaid infants with DOB in FY '07 that were recipients of service. Numerator is medicaid infants with DOB in FY '07 that received at least one EPSDT screen.
Source: NM Medicaid Office. Data from October 1, 2007 - September 30, 2008.

Notes - 2007
Denominator is the number or medicaid infants with DOB in FY '07 that were recipients of service. Numerator is medicaid infants with DOB in FY '07 that received at least one EPSDT screen.
Source: NM Medicaid Office. Data from October 1, 2006 - September 30, 2007.

Narrative:

The EPSDT Advisory Committee of Medicaid membership is comprised of agencies including the Human Services Department (HSD), Department of Health (DOH), Managed Care Organization (MCO) leadership, and professionals that are involved in assuring infant health care. This committee meets quarterly and is working to improve the ability of providers in an MCO and direct fee-for-service environment to provide EPSDT services. The committee is also working to promote use of primary preventive care in the EPSDT category by all ages of children. In addition, due to mounting evidence of developmental and behavioral problems among you children ages one through five, the need to screen and refer for anticipatory guidance has been noted as increasingly essential.

The NM Developmental Screening Initiative (DSI) was created through collaboration among the Early Childhood Action Network (ECAN), the Family Infant Toddler Interagency Coordinating Council (FIT/ICC), Envision New Mexico, the Center for Development and Disability (CDD), New Mexico Pediatric Society, and Parents Reaching Out (PRO), with support from the Commonwealth Fund and Assuring Better Child Health and Development. DSI provides the foundation for wide application of training on use of routine, standardized developmental screening and networking across disciplines throughout the system of care serving young children. In the February 2009, DSI published a developmental screening record booklet (in English and Spanish) as a guide for parents to follow and talk with the provider about their child's development, screens, and immunizations. These booklets are given to parents through hospitals, physician offices, midwives, home visitors, head start and early care and education centers, Public Health Offices, WIC offices, parent conferences, and other appropriate venues.

ECAN, the advisory council for the Early Childhood Comprehensive Systems (ECCS) grant is working on actions steps to educate providers about the use of standardized tools and the 96110 Medicaid reimbursement code. NM Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) advisory council is working to facilitate Ages & Stages Questionnaire (ASQ) training for home visitors and early care and education workers.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	62.4	64.9	76.9	72.1	72.1
Numerator	196	159	143	178	178
Denominator	314	245	186	247	247
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: NM Medicaid Office. Data from October 1, 2007 - September 30, 2008.

Notes - 2008
Source: NM Medicaid Office. Data from October 1, 2007 - September 30, 2008.

Notes - 2007

Source: NM Medicaid Office. Data from October 1, 2006 - September 30, 2007.

Narrative:
Efforts being made by the EPSDT Advisory Committee of Medicaid, the Developmental Screening Initiative, ECAN, and NM Project LAUNCH are described in more detail in HSCI 02.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	58.2	63.1	66.0	66.0	
Numerator	16216	16785	18882	18882	
Denominator	27863	26608	28589	28589	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2009
2008 and 2009 data not yet available.

Notes - 2008
2008 data not yet available.

Notes - 2007
Source: New Mexico Vital Records and Health Statistics.

Narrative:
2007 NM Vital Records data indicates an estimated 59% of NM mothers received a high level of prenatal care (an observed to expected ratio of 80% on this index); 35.5% received intermediate or low levels of prenatal care; and 2.2% reported receiving no prenatal care. Inadequate prenatal care is associated with increased neonatal mortality and low birth weight. Adequate prenatal care, case management and community outreach is associated with improved birth outcomes and cost savings, especially for minority women. Women may not be motivated to seek care, especially for unintended pregnancies. Societal and maternal reasons cited for poor motivation include fear of medical procedures or disclosing pregnancy to others, depression, and a belief that prenatal care is unnecessary. Structural barriers include long wait times, the location and hours of clinics, language and attitude of the clinic staff, cost of services and a lack of child-friendly facilities. NM has long been one of the nation's poorest performers for prenatal care (70% of women, on average, nationally receive adequate prenatal care compared to New Mexico's 59%). Capacity is not adequate to meet the needs for prenatal care. The lack of willing and/or able providers results in some primary care clinics providing little to no prenatal care. High liability insurance rates for pregnancy care and the fear of litigation are significant disincentives to providing pregnancy care. In addition, pregnancy care is labor-intensive and not well reimbursed by Medicaid. Geographical access is a barrier to prenatal care in sparsely populated areas of NM, as it is for all health care. In some entire counties prenatal care is not available.

Strategies to increase access to care include supporting Certified Nurse Midwives and Licensed Midwives, who attend more than one third of the deliveries in New Mexico. The High Risk Prenatal Care fund and local health offices serve indigent women, who often start prenatal care late in pregnancy due to lack of funds. Title V supports four primary care clinics providing care to low-risk medically indigent women. The Birthing Workforce Retention Fund provides awards to prenatal care providers to help defray the cost of malpractice insurance premiums.

In 2008, Maternal Health Program surveyed prenatal care/delivery services in each of NMs 33 counties. This and other studies illustrate deteriorating access to pregnancy care. Since 2005, 3 hospitals ceased delivery service. 12 of 33 counties have no hospital that provides delivery services. 10 (30%) counties have no prenatal care by any type of provider. 8% of the state's 2007 births were to residents of these counties. NM Health Policy Commission surveys show the number of counties lacking an Ob/Gyn practicing obstetrics jumped from 13 to 17 between 2001 and 2006. Increasing liability insurance premiums and low reimbursement rates have driven providers to leave the state or quit obstetric services.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	86.3	98.2	94.3	94.3	
Numerator	254468	252493	235115	235115	
Denominator	294873	257246	249223	249223	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2009
2009 Denominator data not yet available.

Notes - 2008
Denominator: 43% of children, ages 1-20 in 2008 (587,000). Number of children is estimated by Bureau of Business and Economic Research; BBER does not provide projections for individual ages past 20. 43% is the estimated percentage of children living at or below 200% FPL.

Numerator: Source: NM Medicaid Office. Data from October 1, 2007- September 30, 2008. Medicaid report number AH290363
The number of medicaid children age 1-20, that are recipients of service.

Note on BBER data: Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2007

Denominator: 43% of children, ages 1-20 in 2007 (579,589). Number of children is estimated by Bureau of Business and Economic Research; BBER does not provide projections for individual ages past 20. 43% is the estimated percentage of children living at or below 200% FPL.

Numerator: Source: NM Medicaid Office. Data from October 1, 20056- September 30, 2007. Medicaid report number AH290363
The number of medicaid children age 1-20, that are recipients of service.

Note on BBER data: Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
It is difficult to accurately assess the percent of potentially Medicaid eligible children in NM as population poverty estimates based on the 2000 US census become increasingly inaccurate across time with a high population growth rate for youth in NM. Medicaid eligibility measurement is further complicated by: 1) the automatic eligibility assumption for infants born in NM, 2) the recent frequent changes to enrollment requirements from one per year, to once every six months, and back to once per year, and 3) by the Federal changes in eligibility documentation requirements.

Alternate sources of children living at 185% of the poverty level might provide different estimates. State level poverty estimates for children are sparse and may be based on multiple conflicting sources. NM estimates of children living at or below 185% FPL (60%), and therefore potentially Medicaid eligible, are based on a 2002 report of the NM Taxation and Revenue Department. NM uses the most current 2005 population estimates from the University of New Mexico Bureau of Business and Economic Research (BBER) based on US Census data (561,388 children age 0-19). The 2005 National Survey of Child Health (NSCH) -- to be released in 2007 - may provide an indicator of the percent of families with at least one eligible child for use with census estimates of the number of children ages 0-19 years per family to assist in updating eligibility estimates.

Other factors possibly affecting enrollment data may be shifting in the time allowed for eligibility recertification. During the last two years, NM eliminated the 6-month re-certification for children, returning to a one year re-certification. The six-month re-certification resulted in children falling off eligibility, loss of coverage and care. The Department of Health Public Health Offices currently assists with Presumptive Eligibility and Medicaid On Site Application Assistance (PE/MOSAA), which assist many clients with the process of applying for Medicaid as well as the choosing of the Managed Care Organization (MCO) of their choice to provide services.

The DOH works with Medicaid to increase provider reimbursement rates therefore, drawing in more providers within the Medicaid system. The Federal Poverty level for the SCHIP population remains at 235%.

The DOH collaborates with the EPSDT Advisory Committee of Medicaid. Membership is comprised of members from agencies including the Human Services Department (HSD), Department of Health (DOH) MCO leadership, and professionals that are involved in assuring infant health care. This committee meets bi-monthly and is working to improve the ability of providers in an MCO and direct fee for service environment to provide EPSDT services and to promote use of primary preventive care in the EPSDT category by all ages of children. The committee is currently working on avenues that will improve the screening tool/guidelines making

it more user-friendly.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	44.0	59.4	60.4	55.5	55.5
Numerator	34297	45400	47449	46207	46207
Denominator	77965	76493	78498	83330	83330
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not yet available

Notes - 2008
Source: NM Medicaid office. Data are from October 1, 2007 - September 30, 2008.

Notes - 2007
Source: Medicaid MCH Statistical Report FFY 07, number AH280617.

Narrative:
All but 8 of the 33 counties are designated as health professional shortage areas. Six counties do not have a resident dentist.

DOH and Medicaid are working to increase the number of children enrolled in Medicaid, promote access to care, and increase the number of dental Medicaid Providers. The impact of the changes to Medicaid re-enrollment is not yet known.

New Mexico has a lower coverage by dentist compared to nationally. The estimate for the number of dentists in New Mexico ranges from 32.4 to 43.7 per 100,000 populations. This is well below the national rate of 63.6 per 100,000 populations. The dentists in New Mexico are not evenly districted, approximately 50 -- 60% of practicing dentists in the state practice in NE Albuquerque, which is a metro area as compared to the remainder of New Mexico which is rural/frontier. Access to dental care is limited in New Mexico. This can be attributed to the lack of dentists in the state, low reimbursement by Medicaid, and low incomes resulting in large populations with out dental insurance. The Office of Oral Health (OOH) has partnered with private school linked, school based and private providers to increase the number of children receiving preventive dental sealants and treatment services. OOH is continuing to its efforts to work with the NM Dental Board, NM Health and Humans Services Department, the NM Oral Health Council, the legislature, and associations to increase access for dental care. OOH continues to support public-private partnerships with the hope of increasing dental services to lower income children.

OOH continues to use general and federal funds to support low-income children who do not qualify for Medicaid but are in need of preventive and treatment services. OOH continues to use

general funds to support the ongoing dental sealant program. In FY 2009 6,091 children received dental sealants totaling 18,770 teeth sealed and 1,783 were 3rd graders.

OOH continues to work with the NM Oral Health Council and supports the action items developed by the former Governor's Oral Health Council to increase oral health awareness, expand the scope of practice for dental hygienists, and revamp the NM Dental Health Care Board regulation is to increase the number of providers serving the state. Despite the economic turn down the State has maintained the programs budget for State Fiscal Year 10. State Fiscal Year 11 due to proposed budget cuts will reduce the number of children receiving dental sealants and treatment services.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.2	3.5	3.4	3.4	2.6
Numerator	274	274	274	274	236
Denominator	5269	7781	8092	8092	8917
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
7,323 children under 16 received SSI benefits in 2008. The Children's Medical Services Program (CMS) is transitioning to a new data system, and the number of CMS clients that are also SSI beneficiaries is not currently available.

Notes - 2007
Denominator Source:

http://www.ssa.gov/policy/docs/statcomps/ssi_sc/2007/nm.pdf

The Children's Medical Services Program (CMS) is transitioning to a new data system, and the number of CMS clients that are also SSI beneficiaries is not currently available.

Narrative:
Concern continues over gaps in coverage for chronic orthopedic/rehabilitation needs of uninsured children in New Mexico. The merger of Carrie Tingley Hospital (CTH) with the University of New Mexico Medical Center led to a change in the coverage of rehabilitative services. Currently, CTH is not providing rehabilitative services to patients unless they are able to pay out of pocket although funding was appropriated by the Legislature to CTH in the l980's to cover such costs. To mitigate this CMS places children with certain diagnoses on the New Mexico Medical Insurance Pool. This coverage is far greater than the $15,000 limit for CMS CYSHCN and more comprehensive. The gap in coverage for chronic orthopedic/rehabilitative services results in disparate coverage for immigrant (mostly Hispanic) children, since most are unable to pay out of pocket. The 2007 Legislature awarded CMS $500,000 in additional funds: $300,000 was used to

increase enrollment onto NMMIP with an emphasis on children with orthopedic needs, $100,000 was used to enhance services to the Deaf/Hard of Hearing Community, $100,000 to the Blind and Visually Impaired Community. In FY 2011 these contracts will be cut by 12%. In 2009 CMS met with CTH to discuss care for CYSHCN with orthopedic needs. Initially an agreement was developed where CTH would provide care to non-Medicaid eligible CYSHCN when the care was 'medically necessary'. That determination was to be made by the Orthopedic Specialist, with appeal privilege given to the CMS Medical Director. In 2010 however, CTH reversed this decision. The program continues to utilize NMMIP to cover this unmet need. The initial $500,000 from the legislature was part of the recurring budget for CMS but that amount has been diminished over time.

SSI and Medicaid/SCHIP continue to be the major providers of the rehabilitative care in NM. This begins to close the gap on uninsured children who need orthopedic and rehabilitative care. A December 2009 breakdown of SSI recipients by county for children under 18 is as follows:
Total New Mexico 8,942
Bernalillo 2,552
Catron *
Chaves318
Cibola 159
Colfax 52
Curry 263
DeBaca 11
Dona Ana 1,105
Eddy 163
Grant 99
Guadalupe 19
Harding *
Hidalgo 20
Lea 183
Lincoln 46
Los Alamos *
Luna 136
McKinley 708
Mora 28
Otero 206
Quay 51
Rio Arriba 150
Roosevelt 95
Sandoval 380
San Juan 717
San Miguel 168
Santa Fe 533
Sierra 40
Socorro 150
Taos 87
Torrance 72
Union 10
Valencia 405

*Data not shown to avoid disclosure.

SSI beneficiaries are offered care coordination by the CMS CYSHCN program. CMS Social Workers also assist SSI recipients turning 18 to apply for benefits as adults. At one time CMS received a monthly list from Disability Determination Services (DDS) providing names of all families allowed or denied benefits. CMS would contact these families and inform them of services offered by the program, such as care coordination and information about PRO a Parent

advocacy organization. Due to HIPAA, DDS is unable to provide these reports to CMS.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	6.4	5.6	6

Narrative:
The most recent birth + Medicaid report was done in 2000.

In New Mexico and the United States, low birthweight increased by more than one percentage point from 1989-2005. In New Mexico, 8% of infants were premature in 2004-2005. Compared to the U.S., New Mexico is doing better but still has not reached the Healthy People 2010 goal. Disparities persist by age, race, marital status, and education. Low birthweight infants were predominant among first-time mothers and women over 34 years of age. Native American women, unmarried women and women with less than a high school education also had higher proportions of LBW infants compared to all New Mexico women. Preterm births were predominant among first-time mothers, moms over 34 years of age, Native American mothers, those with less than a high school education, and mothers who lived in Bernalillo County. In 2004-2005, 10% of newly-delivered NM moms had an infant admitted to an intensive care unit after birth. The majority of NM infants stayed in the hospital for one or two days (64%), followed by three days (14%) and six days or more (6%).

The recent increase in births by elective and repeat cesarean section (scheduled cesarean section) contributes to the rate of late preterm births, which constitute a large proportion of low birth-weight babies, as there are no perfectly accurate predictors of fetal weight or gestational age against which to plan a delivery. Similarly, increases in elective and scheduled inductions contribute to the cesarean section rate, late preterm births and low birth-weight babies.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	payment source from birth certificate	6	6	6

Narrative:
The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has

adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid.

Infant deaths per 1000 live births for NM residents has declined from 7.1 in 1998 to 6.3 in 2004, though this is an 11% increase from the 2002 rate. Data on this indicator are not available for Medicaid and non-Medicaid populations, but this decline was observed across all race/ethnicity groups. The 2004 Vital Records report shows that in 2003 the NM infant mortality rate was 21.7% lower than the US rate of 6.9% and 10% lower than that of the the Mountain Census Region. This same report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and that their infants were more likely to be low birth weight compared to Medicaid mothers in managed care. Medicaid mothers were less likely to access 1st trimester prenatal care, and they were more likely to give birth to low birth weight infants (10% among fee-for-service, 8.4% among Salud!, and 6.9% among non-Medicaid births)

In 2007, New Mexico's infant mortality rate was 6.0 per 1,000 live births. NM Vital Records and Health Statistics is still slightly delayed in releasing 2008 and 2009 data due to their conversion to a new web-based system, during which they also adopted the NCHS birth certificate standard. Infant deaths by payer of care should be available when these data are released.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	68.8	78.8	73.8

Notes - 2011
2008 and 2009 Birth file not yet available

Narrative:
The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid.

The PRAMS report of 2004-2005 births shows that by payer of care, 61.5% of women on Medicaid received adequate or intensive prenatal care, 55.9% of Indian Health Service recipients received adequate care, 72.1% of private insurance recipients received adequate care, and only 52.6 percent of women with no insurance received adequate care. According to the 2006 report by New Mexico Vital Records and Health Statistics, (NMVRHS) 71.6 percent of births were to mothers that began prenatal care in the first trimester. In the 2004-2005 PRAMS report women cited Inability to get an appointment, not having money or insurance, and not having a Medicaid card as the top three reasons they couldn't get prenatal care when they wanted it. In 2006, 67.9% of Medicaid covered births were to women that began prenatal care in the first trimester, and 78.2% of births covered by other kinds of insurance were to women who began care in the

first trimester. NMVRHS has not yet released birth data by payer of care for 2007 and 2008. Issues surrounding access to health care for pregnant women are discussed in the narrative for National Performance Measure 18.

Women may not be motivated to seek care, especially for unintended pregnancies. Societal and maternal reasons cited for poor motivation include fear of medical procedures or disclosing pregnancy to others, depression, and a belief that prenatal care is unnecessary. Structural barriers include long wait times, the location and hours of clinics, language and attitude of the clinic staff, cost of services and a lack of child-friendly facilities.

The Maternal Health Program provides logistical and program support for the delivery of prenatal care in 10 Public Health Offices (PHOs) throughout the State. These PHOs, located in Regions 4 and 5; Lea, Eddy, Lincoln, Sierra, Socorro, Luna and Torrance Counties, serve at least 700 low-risk women per year who would not otherwise have access to prenatal care. 90% of these women are uninsured, poor, and not eligible for Medicaid coverage for prenatal care. Ten percent of these women are Medicaid-covered but lack transportation to other prenatal care providers. Services the Program provides include evidence based practice protocols, documentation compliance review, training workshops and continuing education opportunities, text and web based resources, client education materials, access to routine laboratory testing for patients through the Program's contracts with SED Medical Lab, pharmaceuticals and medical supplies through the Public Health Division Pharmacy, and technical support.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	69	69.1	69.1

Notes - 2011
2008 and 2009 birth file not yet available.

Narrative:
The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid.

The 2003 report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care. New Mexico Vital Records and Health Statistics (NMVRHS) reports in 2006 that 61.1% of births were to women whose prenatal care use was considered at least "adequate." Sixty-two percent of Medicaid births and 64.5% of non-Medicaid births were to women with adequate usage.

NMVRHS began using a new, web-based birth certificate in July, 2007. 2007 and 2008 prenatal care by payer of care data will be available when the transition to the new system is complete.

The lack of willing and/or able providers results in some primary care clinics providing little to no prenatal care. Also, high insurance liability rates and the fear of litigation are significant disincentives for physicians to provide pregnancy care. Additionally, pregnancy care is labor-intensive and is not well reimbursed by Medicaid, which reimburses at 85% of the cost of services.

In 2008, The Maternal Health Program conducted phone surveys of prenatal care/delivery services in each of New Mexico's 33 counties. This and other studies indicate deteriorating access to pregnancy care. Since 2005, three hospitals stopped delivery service. Twelve of 33 (36%) counties have no hospital that provides delivery services. Seven of 33 (21%) counties have no prenatal care providers: no obstetricians, no family practice physicians, no midwives. 11.6% of the state's 2007 births were to residents of these counties. Increasing liability insurance premiums and low reimbursement rates have driven some providers to leave the state or discontinue obstetric services. Initiatives to recruit and retain providers in these underserved areas are continually being developed, evaluated and reinforced.

The Birthing Workforce Retention Fund was passed as legislation in 2008. This fund makes direct awards to individual doctors and midwives to help defray the costs of their malpractice insurance premiums. NM DOH Rural Healthcare Practitioner Tax Credit Program incentivizes health care providers, including Certified Nurse Midwives, who provide care in rural, underserved areas with an income tax credit of $3,000 to $5,000 for each year they maintain a practice in an eligible locale. Proposals are being developed for alternatives to the torts system for compensating those with poor birth outcomes and for reducing negligent practice thereby increasing the number of individual practitioners willing to maintain obstetrical or midwifery practices in the state.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	235

Narrative:
In New Mexico, infants age 0-1 are eligible for Medicaid if their family income is less than or equal to 185% of the federal poverty level (FPL), provided they meet other criteria. Infants are eligible for SCHIP if their family income is less than or equal to 235% FPL.

The Family Health Bureau (FHB) staff participates in the EPSDT-Medicaid Advisory Committee. FHB works with partners to identify statewide strategies to address issues of uninsured or underinsured. Families FIRST and CMS programs complete Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) applications for eligible children or youth.

The MCH programs' ability to maintain and improve HSCIs has been primarily from PRAMS, including addition of questions specific to indicators, vital records access, Medicaid & WIC data, and from SSDI support to strengthen data linkage capacity. Improvement in vital records data is

expected with electronic record implementation in 2007, including payment source data needed for program planning related to Medicaid/non-Medicaid, or un-reimbursed care.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	235

Narrative:
In New Mexico, children <19 are eligible for Medicaid if their family income is less than or equal to 185% of the federal poverty level (FPL), provided they meet other criteria. Children age 1-18 are eligible for SCHIP if their family income is less than or equal to 235% FPL.

The Family Health Bureau (FHB) staff participates in the EPSDT-Medicaid Advisory Committee. FHB works with partners to identify statewide strategies to address issues of uninsured or underinsured. Families FIRST and CMS programs complete Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) applications for eligible children or youth.

A current barrier to access is the requirement of a birth certificate to qualify for Medicaid. The Department of Health (DOH) is working collaboratively with the Human Services Department (HSD) to identify community events that would provide opportunities for outreach and Medicaid enrollment of eligible children. DOH is also working collaboratively with HSD to increase the number of eligible children enrolled in Medicaid, and to address the birth certificate requirement to qualify for Medicaid. DOH will continue to reach out to children and families to increase the number of children who are insured. This includes the efforts of Families FIRST and CMS staff who are actively involved in assisting families to complete the PE/MOSSA application.

The Children's Cabinet is working with the Governor and State Legislature to address universal coverage for children. In July 2006 Medicaid's six month reenrollment was changed back to the one year reenrollment requirement. Information is being shared with families about the availability of funds to assist families with the cost of health insurance premiums. HSD has increased the amount of income that can be disregarded and the amounts that can be deducted from gross income, making it possible for children age 0-5 to receive SCHIP at up to 300% FPL. The Children's Cabinet plans to continue to work with the Governor and the State Legislature to implement universal health care coverage for all New Mexicans, including children.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2011
SCHIP does not cover pregnant women in New Mexico.

Narrative:
Pregnant women are not covered by SCHIP in New Mexico. Pregnant women qualify for Medicaid if their income is less than or equal to 185% FPL, provided they meet other criteria.

The New Mexico Medicaid policy was successfully changed, and the Maternal Health Program participated in developing systems so that professional out-of-hospital birth attendants will be paid by Medicaid Managed Care Organizations for delivery services even when liability insurance cannot be obtained at less than 25% of the provider's practice income. A home birth is less expensive, and for some women it is their preference. This should improve pregnancy care access.

MCH is meeting with the Public Health Division's Health Systems Bureau personnel, Governor's Women's Health Commission, leadership of the New Mexico Primary Care Association, and state Medicaid administrators to identify strategies for increasing access to prenatal care throughout the state.

Title V MCH and State General funds are being used to cover services to pregnant women (High Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of health care coverage.

The MCH programs' ability to maintain and improve HSCIs has been primarily from PRAMS, including addition of questions specific to indicators, vital records access, Medicaid & WIC data, and from SSDI support to strengthen data linkage capacity. Improvement in vital records data is expected with electronic record implementation in 2007, including payment source data needed for program planning related to Medicaid/non-Medicaid, or un-reimbursed care.

A thorough discussion of poverty level as a measure of eligibility for aid is available in the narrative for Health Status Indicator 11.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death	2	No

certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	2	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011
An attachment is included in this section.

Narrative:
Please see the attached document detailing availability and linkage capacity of Maternal and Child Health data.

NM traditionally has had five Maternal and Child Health Epidemiologists and currently (as of June, 2010) has two. MCH Epidemiology personnel have either retired or taken positions elsewhere, and resource shortages have resulted in delays in replacing two of the three vacant MCH Epidemiologist positions. The Title V agency has access to aggregate data reports and/or individual electronic data files within the DOH and across many agencies for assessment and evaluation purposes. The most important weaknesses may be for evaluation studies and benefit-cost analysis, partially due to lack of cost data. Most data are from surveillance or required reporting systems.

The Maternal and Child Health Epidemiology program regularly receives birth and death files from the Bureau of Vital Records and Health Statistics (VRHS), and the PRAMS survey is housed within the MCH Epi program. Both of these inform the majority of Title V data requirements. For NM PRAMS, data are available starting with 1997 births.

In addition, MCH Epi acquires data from the Human Services Department for Medicaid and EPSDT data. WIC data are available through the Family Food and Nutrition program which is housed in the same bureau as the MCH Epi. program (Family Health Bureau.) Vital Records, PRAMS, and YRRS data are also on the Department of Health's online data query system IBIS: http://ibis.health.state.nm.us/home/Welcome.html Record-level hospital discharge data are available from the Health Policy Commission upon request. The Department of Health recently implemented the Billing and Electronic Health Records (BEHR) system to monitor client encounters in DOH funded facilities, and BEHR staff are working to improve the system's reporting capacity. MCH Epi analyzes and reports data from several national surveys including

the National Survey of Children's Health and the National Survey of Children with Special Health Care Needs, and the National Immunization Survey. Children's medical services collects Newborn Hearing Screening and Birth Defects data.

Linkage:

Linkage is an ongoing priority, but is hindered by a lack of personnel resulting from budget cuts and from the hiring freeze that went into effect in November of 2008. A preliminary, descriptive analysis of linked birth defects+ birth+death was completed in the first quarter of 2007. VRHS performs linkage of birth and death files annually. PRAMS and WIC data have been linked and need to be analyzed. Birth and Death records are linked annually by VRHS. Birth defects registry data and birth certificate data are linked by the Environmental Epidemiology Program.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2011

Narrative:
Initiation of tobacco use among NM youth often occurs earlier than the high school years. In order to obtain prevalence estimates of substance use among pre-high school students, a middle school (MS) YRRS was conducted in 2007. The 2007 MS YRRS complemented the regular HS YRRS, also conducted in 2007.

Among 9th -- 12th grade students, 18.0% first smoked a whole cigarette before age 13. Because the school-based YRRS does not represent high school dropouts, age at first use is likely an underestimate, especially among students in higher grade levels when substance users are more likely to have dropped out.

There was an 86% increase in the prevalence of lifetime cigarette smoking from 6th (24.8%) to 8th grade (46.2%) and an increase of 24% from 9th (52.3%) to 11th grade (64.9%). The prevalence for 12th grade was 59.9%. The prevalence of current cigarette smoking (smoked a cigarette in the past 30 days) increased by 92% from 6th (8.5%) to 8th grade (16.3%), and by 18% from 9th (22.2%) to 11th grade (26.1%). The prevalence for 12th grade was 25.2%. There was an 83% increase in the prevalence of current cigar smoking (smoked cigars, little cigars, or cigarillos in the past 30 days) from 6th (6.3%) to 8th grade (11.5%). There was a slight decrease in the prevalence of cigar smoking over the high school years, although these differences were not statistically significant (9th = 19.2%; 10th = 19.4%; 11th = 18.1%; 12th = 18.1%). The prevalence of past 30-day smokeless tobacco use increased by 27% from 6th (4.1%) to 8th grade (5.2%), although there were no statistically significant differences by grade level. There was a 63% increase in prevalence from 9th (9.0%) to 11th grade (14.7%), while the prevalence for 12th grade (9.6%) was lower than for 11th grade. There were no statistically significant differences by grade level.

The Tobacco Use Prevention and Control (TUPACAC) program and its partners use a comprehensive, evidence-based approach to promote healthy lifestyles free from tobacco abuse and addiction. TUPACAC follows best practice recommendations from the Centers for Disease Control and Prevention (CDC).

I n FY09, TUPACAC awarded $9.1 million of Master Settlement Agreement funds to 73 community organizations and schools through deliverables-based contracts for tobacco control and prevention services for New Mexicans. These services decrease the harmful and addictive use of tobacco outside of traditional, sacred or ceremonial purposes. The result is a reduction in tobacco-related illness, saved lives and saved money.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The priorities and performance measure activities are inherent in the program activities undertaken by the Title V funded programs.

IV. A. 1. Maternal Health Program

Maternal Health provides statewide public health leadership to promote and improve maternal health care for underserved women in the state and improve the health of childbearing women by promoting systems that will strengthen community health and improve opportunities to assist families. The program administers the High Risk Prenatal Fund and the Birthing Workforce Retention fund, and is responsible for the budgets and contracts of each program. MH licenses and regulates both Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs) in the state, increasing access to care for women in some of the most rural areas of NM. MH provides protocols, technical assistance and guidance to 10 Public Health offices that provide prenatal care to uninsured ad underinsured women.

IV. A. 2. Child Health

The Child Health program builds on existing resources, aligns early childhood comprehensive systems and information sharing, and partners with the Children's Cabinet to address disparities in early childhood health and well-being such as: access to early childhood health, education, and family support related activities. The program also provides statewide public health leadership to improve the health of children ages birth-12, emphasizing early childhood wellness and family involvement, and strengthens community health to help families to adopt healthy behaviors for themselves and their children. This work is accomplished through building collaborations with public/private partners to champion services for children and families: Early Childhood Action Network (ECAN), experts in the field of early childhood, connecting theory, research, and practice to develop policy recommendations; Family Leadership Action Network (FLAN) supports family empowerment by promoting parent-to-parent peer coaching with facilitated learning methods. Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) promotes the wellness of young children up to age eight through a demonstration project -- the Santa Fe Children's Project. Additionally, Title V funds a position in the office of injury prevention and the office of adolescent health, both of which work to address federal and state child and adolescent health priorities.

IV. A. 3. Family Planning Program

To improve maternal and infant health outcomes the NM DOH Family Planning Program provides access to affordable contraceptive services, supplies and information to all who want and need them. Priority is given to persons from low-income families at or below 250% of poverty level. The reproductive health services help women and men to plan their families and prevent unintended, including teen, pregnancies.

NM DOH Family Planning Program provides clinical reproductive health services statewide. Clinical services include providing a contraceptive method and/or a clinical exam visit. The clinical exam visit includes: a medical history/physical, family planning counseling, pregnancy testing (if needed), laboratory tests (as needed), testing and counseling for sexually transmitted infections (STIs), and a supply of a contraceptive method of choice. NM DOH FPP also provides educational services including community education & outreach and evidence-based teen pregnancy prevention programs such as comprehensive sex education, service learning programs, male involvement program and adult-teen communication program.

IV. A. 4. Children's Medical Services

Children's Medical Services (CMS) is federally funded through Title V Maternal and Child Health block grant and state general funds to serve as a safety net for the provision of medical management, payment for medical services, diagnostic studies and service coordination for Children and Youth with special health care needs (CYSHCN) throughout New Mexico. CMS is housed statewide in the local Public Health Offices.

Children and Youth with Special Health Care Needs (CYSHCN):
This program provides comprehensive medical care and critical care coordination for children with chronic medical conditions ages birth to 21 who are uninsured or underinsured and are not eligible for Medicaid and who meet CMS medical eligibility and income guidelines of under 200% of poverty. In some cases, Medicaid eligible children and youth receive Medicaid for the coverage of their chronic medical conditions and care coordination from a CMS Social Worker.

Multidisciplinary Pediatric Specialty Outreach Clinics:
These community-based pediatric specialty clinics provide multidisciplinary, coordinated diagnostic and/or on-going medical care to children and youth with pulmonary, endocrine, cleft palate, neurological, metabolic and genetic conditions. This service is available to all CYSHCN. Fees are charged for these services. Payor sources include private insurance, Medicaid and CMS for those who are not Medicaid eligible. CMS holds approximately 130 clinics per year.

Transition services for Youth with Special Health Care Needs.
CMS covers adolescents aged 14-21 years who are uninsured or no longer qualify for Medicaid. Age 14-21 is a critical time to intervene allowing youth to transition from pediatric to adult health care and to become ready for the work place. Care coordination plays a critical role in assisting the youth in obtaining educational support and community services as many of these youth who go unassisted during this life stage "fall through the cracks" and go without support and critical medical care.

Family Infant Toddler Program:

Service Coordination and/or Social Work services for children ages birth to 3 years of age with or at risk for developmental delay.

Newborn Screening Program:
Follow up and care coordination for infants, who fail their newborn hearing screen, and/or are found positive on the newborn genetic screening. The program expanded screening for 28 conditions per a legislative mandate in 2005. Newborn Screening for all newborns prior to discharge from the birthing hospital is mandated by New Mexico state law.

NM Medical Insurance Pool (NMMIP) Insurance Program

CMS will purchase NMMIP coverage for CYSHCN who have no insurance or Medicaid whose medical conditions are or are anticipated as being very high cost. NMMIP is also purchased for youth who are transitioning out of CMS and are not eligible for other insurance programs.

B. State Priorities

The ten priorities for the 2011-2015 Needs Assessment Cycle are:

1. Increase accessibility to care for pregnant women and mothers that provides care before, during and after pregnancy
2. Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.
3. Increase awareness and availability of family planning and STD prevention options.

4. Promote awareness of childhood injury risks and provide injury prevention strategies to families and caregivers of children.
5. Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options.
6. Increase the proportion of mothers that exclusively breastfeed their infants at six months of age.
7. Decrease disparities in maternal and infant mortality and morbidity.
8. Promote healthy lifestyle options to decrease obesity and overweight among children and youth.
9. Maintain specialty outreach clinics for children and youth with special health care needs.
10. Improve the infrastructure for care coordination of children and youth with special health care needs.

Many of the priorities encompass the priorities from the previous cycle. Two were replaced, and one was added. The following is a discussion of why the current priorities were selected:

Access to Care

2005: Improve access to and use of health and health related services including health insurance and other coverage such as Medicaid, S-CHIP for all MCH population groups.

Access to care was the number one priority identified through the regional meetings and in the online survey. The 2005 priority was replaced with the 2010 priority to reflect a more realistic scope for the Family Health Bureau (FHB).

2010: Increase access to care for pregnant women and mothers that provides care before, during and after pregnancy

CSHCN

2005: Improve the transition from childhood ages to young adulthood for children and youth with special health care needs to assure uninterrupted access to health care and related transition services.

The CMS program and its stakeholders elected to replace the 2005 priority with the two priorities below to more accurately reflect their greatest current need and capacity with regard to staffing and resources.

2010: Improve the infrastructure for care coordination of children and youth with special health care needs, and
Maintain specialty outreach clinics for children and youth with special health care needs.

Maternal Health

2005: Improve indicators of health in the preconception and perinatal periods, including but not limited to smoking, alcohol, folic acid use, family violence, intention of pregnancy, access to and use of health care, and maternal depression.

The 2005 priority was replaced with the following four priorities to identify more specific areas of focus that are within the scope of the Family Health Bureau, and that reflect the organizational structure of FHB and its partners. For example, FHB collaborates with Children, Youth and Families Department (CYFD) to address violence, and with various clinical practitioners for maternal screening and treatment.

2010: Increase accessibility to care for pregnant women and mothers that provides care before,

during and after pregnancy

2010: Decrease disparities in maternal and infant mortality and morbidity.

2010: Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.

2010: Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options.

Violence

2005: Reduce indicators of violence affecting the MCH population with focus on reducing the number of children witnessing violence, the rate of substantiated child abuse and on reducing the percent of women who report physical abuse before and during pregnancy.

The 2005 priority was rephrased for simplification and to indicate a specific focus on infrastructure, and to include attention to youth interpersonal violence.

2010: Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.

Teen Births

2005: Reduce unintended births to teens, and the related prevalence of sexually transmitted infections among teens.

The 2005 indicator was rephrased to include all persons, including men, who benefit from family planning services, and to fit in to the scope of FHB and Title V programming.

2010: Increase awareness and availability of family planning and STD prevention options.

Healthy Weight

2005: Promote healthy weight and physical fitness among parents and their children; reduce overweight and obesity in the MCH population with focus on early childhood and adolescents to reduce psychological and chronic disease problems.

The 2010 priority reflects the results of the meetings and online survey. Maternal weight was not among the 25 priorities identified by Needs Assessment participants.

2010: Promote healthy lifestyle options to decrease obesity and overweight among children and youth.

Injury

2005: Reduce rates of fatal and non-fatal unintentional injury among children and teens, with emphasis on interventions to prevent motor vehicle crash and household accident injuries.

The 2010 priority was rephrased for simplicity.

2010: Promote awareness of childhood injury risks and provide injury prevention protocols to families and caregivers of children.

Youth Development, Mental Health

2005: Promote positive youth development experiences with emphasis on building personal and social assets at the family, school and community levels, and with a view to reduce the proportion of youth who engage in risk behaviors that have serious life-long consequences.

The 2005 priority was replaced with the following two priorities to better reflect the scope of FHB's Title V programs.

2010: Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options.

2010: Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.

A new priority was selected for 2010:

2010: Increase the proportion of mothers that exclusively breastfeed their infants through six months of age.

Increasing exclusive breastfeeding was identified as a priority that would likely respond well to New Mexico's current efforts, and that benefits mothers and infants with relation to other priorities above such as healthy weight and infant morbidity.

Replaced:

2005: Strengthen the role of males in MCH through promotion of effective initiatives in healthy fatherhood and in reproductive health through male involvement strategies.

Male Involvement ranked near the bottom in the survey in all counties and by all demographic groups.

2005: Monitor the health of immigrants in the MCH population.

The immigrant population is part of the larger MCH population. It was not specifically identified as a priority during the needs assessment regional meetings.

Adoption of the new State Performance Measures:

FHB managers and staff considered the new state performance measures in the context of S.M.A.R.T (Specific, Measureable, Attainable, Realistic and Timely) criteria, and with regard to the capacity of the Family Health Bureau and its partners. All of the State priorities above are addressed through the National and State Performance measures.

The State priorities that did not meet the S.M.A.R.T. criteria were:

SPM 01: pertaining to counties and tribal entities implementing positive youth development strategies. This was replaced because the state has very limited capacity to measure it.
SPM 04: pertaining to children witnessing violence.
This measure was replaced because it is primarily the responsibility of another department. (CYFD)

SPM 05: pertaining to the healthy birth "index."
This measure was replaced because most of the criteria are addressed in other measures and indicators, and the likelihood that the State could effect improvement on all six criteria collectively was deemed low.

SPM 08: pertaining to syphilis screening for new mothers

This measure was replaced because the state has limited capacity to measure it and FHB felt that other issues were more urgent.

State Performance Measures that were retained were:

SPM 02 (Now SPM 01): Increase the percent of mothers receiving support services through community home visiting/support programs
SPM 03 (Still SPM 03): Reduce unintended pregnancy in New Mexico to less than 30% of live births.
SPM 06 (Now SPM 07): Reduce the proportion of women who report being physically abused by their husband or partner during pregnancy

New state performance measures are:

SPM 02 Decrease the percent of women with a live birth who had no health care coverage for prenatal care
SPM 04: Decrease the percent of women initiating prenatal care after 10 weeks that did not get care as early as they wanted
SPM 05: Increase the percent of children under age 12 who are appropriately secured while in a motor vehicle
SPM 06: Decrease the percent of middle school students that report using alcohol within the past 30 days
SPM 08: Increase the proportion of mothers who exclusively breastfeed their babies through six months

Two measures that may be added later depending on FHB's capacity to measure them are:

1. Increase the percent of asthmatic children that have an asthma action plan
2. Increase percent of women who are clients of public health offices that are screened for depression during prenatal and postpartum health office encounters.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	16	17	15	30	20
Denominator	16	17	15	30	20
Data Source				Children's Medical Services program	Children's Medical Services
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Confirmed cases needing treatment were:

Phenylketonuria
congenital Hypothyroidism
Sickle Cell Disease
Biotinidase Deficiency
Congenital Adrenal Hyperplasia
Cystic Fibrosis

Notes - 2008
Confirmed cases needing treatment were:

Phenylketonuria
Congenital Hypothyroidism
Duarte-Galactocemia
Sickle Cell Disease
Hemoglobin=FD/G
Congenital Adrenal Hyperplasia
Cystic Fibrosis
Amino Acids
Acylcarnitines
Hemoglobin Traits

Notes - 2007
Source: Children's Medical Services program, New Mexico Department of Health.

a. Last Year's Accomplishments
July 2008-June 2009

Direct: 8 outreach metabolic clinics include long term follow-up of adults after age 21 with metabolic disorders, Care coordination provided to families by community based CMS social workers.

Enabling: Long-term services begin with diagnosis through life-span Positive case referred for care coordination by a Children's Medical Service (CMS) social worker, overseen by CMS Newborn Screening Nurse consultant. Follow-up system consists of Oregon State Public Health Lab, Oregon State Specialists, CMS Nurse Consultant, UNM specialists, CMS social worker, UNM genetic counselor, metabolic nutritionist.

Population-Based: Preventive intervention includes working with 34 birthing facilities & midwives to improve collection of newborn screens. Disease prevention through long-term follow-up program: CMS nurse consultant, CMS social workers, specialists. Public education includes information on Newborn screening: brochures, waiver translated in Spanish. Newborn Screening website accessible for both Public & professional staff & updated yearly.

Infrastructure Building: Activities: training, educational materials & support to Labs, OB staff who collect Blood spots. Each facility receives updates monthly of practice profile, a QA tool updating them on their progress. Educational materials are provided to physicians, nurses, midwives, social workers. Database linkage between newborn genetic screening, hearing screening

program & vital records, electronic birth certificates are being strengthened.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monthly Memo's sent out with practice profile, informing facilities on their performance on newborn screens submitted.			X	
2. Continued Development of standard/guidelines for expanded screening. Collaboration of a data system to include Newborn screening, newborn hearing, vital records and birth defects.				X
3. Monitor implementation of a long-term comprehensive Follow-up system. Which will include CMS Nurse Consultant, CMS social workers, Medical specialists, PCP's, Family and Oregon State Public Health Lab.				X
4. Working with facilities on a QA plan, for education, and training of staff ongoing.				X
5. Working with OB doctors to distubute Newborn screening pamphlets to mothers prior to delivery.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Direct: UNM will provide outreach clinics and follow-up to clients across New Mexico that require their services. Social workers for CMS will receive referrals form the Newborn Genetic Screening (NGS) program for care coordination.

NGS nurse consultant works with families to ensure medical home placement..

Enabling: The NGS program works with UNM metabolic team &Sickle cell counsel to strengthen long-term follow-up process. Programs meet quarterly to review referred cases for continuity of care, to ensure families or clients receive optimal care.

All hemoglobinopathies referred to Sickle Counsel for education and further testing of family members. Each case is reviewed quarterly to ensure follow-up.

Midwives going through licensing in the State of New Mexico are required to do a face to face NGS training. This has increased awareness of and participation in the program.

Population: Preventive includes referring clients to specialists, case management, and follow-up on presumptive positive cases to ensure that confirmatory testing is done.

Infrastructure: Quality assurance through monthly practice profile reports to each birthing facility and Midwives. Updating facilities/Midwives on current events on NGS by monthly memos. Placement of Newborn screening kits in Public Health areas to ensure families have access to forms for repeat screens. NGS program developed and distributed guidelines for emergency preparedness in Newborn Screening.

c. Plan for the Coming Year
July 2010-June 2011

Direct: 8 outreach clinics and follow-up to clients across the State of New Mexico who require services to include adults that may not be able to travel to major facilities for follow-up appts.

University Genetic counselors to work closely with education and setting up of CF sweat testing for individual clients, with positive newborn screening for Cystic Fibrosis.

Enabling: To ensure quality care is provided to all clients with a positive test, they are referred to social workers statewide for case management, UNM Specialists, PCP's, Presbyterian specialists and Oregon State Public Health Labs and their Specialists.

Newborn screening program along with nutritionist at university hospital will work closely to advocate, to ensure clients with special formula needs, will receive formula from insurances.

The Newborn Screening program will be gathering outcome data from CMS Social workers for long term follow-up. Data will be entered through the new data base challenger soft, where reports can be generated.

Population Based Services
Preventive interventions will include education of prenatal mothers about Newborn screening, through educational materials given at prenatal visits.

Infrastructure Building Services
To continue quality of care and proper collection process, the Newborn Screen program plans to re- Visit birthing facilities and midwives statewide to educate on current events in the newborn screening program.

Education will be done to all NICU's in the State on the new guidelines for screening Preterm, low birth weight, and sick newborns.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**28640**					
Reporting Year:	**2007**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	28640	100.0	13	1	1	100.0
Congenital	28640	100.0	160	15	15	100.0

Hypothyroidism (Classical)						
Galactosemia (Classical)	28640	100.0	21	0	0	
Sickle Cell Disease	28640	100.0	0	0	0	
Biotinidase Deficiency	28640	100.0	15	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	28640	100.0	114	5	5	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48	48	52	55	55
Annual Indicator	53.2	53.2	53.2	53.2	53.2
Numerator					
Denominator					
Data Source				http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm	http://mchb.hrsa.gov/cshcn
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	55	55

Notes - 2009
Please see notes from 2006 and 2007.

Notes - 2008
Please see notes from 2006 and 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
July 2008 -- June 2009

Direct: Children's Medical Services (CMS) continued efforts to expand medical home concept by discussing the concept at meetings/conferences. CMS social workers continued family-centered approach in care coordination, including involving youth in transition planning.

Enabling: Ensured family participation in Maternal and Child Health (MCH) Collaborative, New Mexico Interagency Coordinating Council, Newborn Hearing Screening Advisory Council, and AMCHP Conference. CMS contracted with family organizations to ensure that families partner in decision-making at all levels. CMS sponsored the Parent Leadership Training through Education for Parents of Indican Children with Special Needs (EPICS). A few participants from the previous year's Institute were trainers at this year's Institute. The Newborn Hearing Screening (NBHS) program sponsored a parent to attend the National HDI Conference.

Population-Based: Family Organizations provided input into Program Activities during meetings. CMS staff met with Social Security Disability Determination Unit to discuss the need for SSI Reports to be sent to CMS who can make referrals to Parent Reaching Out (PRO). Family Organizations were invited to provide input into CYSHCN Program Activities utilizing information from previous Title V Performance Measures submitted.

Infrastructure Building: CMS program manager served on the CYSHCN Integrated Services board for the Navajo Nation with a focus on youth transition. The NBHS coordinator served on the board of the Family to Family Health Information Center with PRO.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Establish contracts with family organizations and/or selected family members to assure family involvement in decision making.			X	
2. Family organizations will provide education & training to CMS social workers and other providers on family involvement practices.		X		

3. Establish new or utilize existing councils to review CYSHCN survey outcomes and to develop plan for improvement.				X
4. Analysis of NM specific data in national survey of CYSHCN to identify key issues to improve performance				X
5. Recruit parent representation onto the Newborn Genetic Screening Advisory Council			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2009--June 2010

Direct: CMS works to expand medical home concept in New Mexico, promoting the discussion of the concept at professional meetings and conferences. CMS has a family-centered approach in care coordination, including involving youth in transition planning for State CYSHCN Program. CMS makes referrals to family support organizations for family to family connections.

Enabling: CMS sustains family participation in the MCH Collaborative, NM Interagency Coordinating Council (ICC), NBHS Advisory Council, and AMCHP Conference. CMS contracts with family organizations to ensure that families partner in decision-making at all levels; scope of work includes participation in local, State and National meetings/conferences, training for staff/families, and an advisory role regarding policy.

Population-Based: CMS sustains family participation in MCH Collaborative, referrals to PRO, the NM ICC, the NBHS Advisory Council, AMCHP Conference, and efforts to address integration of Medical Home. CMS recruited a parent representative to join the Newborn Genetic Screening Advisory Council. Family Organizations are invited to provide input into CYSHCN Program activities during scheduled meetings.

Infrastructure Building: CYSHCN Program sustains partnerships with family organizations, seeks input in all Program areas and involves them in decision-making. The NBHS coordinator continues to participate on the board of the Family to Family Health Information Center with PRO.

c. Plan for the Coming Year
July 2010 -- June 2011

Direct: CMS will continue efforts to expand the medical home concept in New Mexico, promoting the discussion of the concept continuing at professional meetings and conferences. Continue on-going family-centered approach in care coordination, including involvement of youth in transition planning for State CYSHCN Program. Continue referrals to family support organizations for family to family connections.

Enabling: CMS will continue assisting families to participate in the MCH Collaborative, the NM Interagency Coordinating Council, the Newborn Hearing Screening Advisory Council, and the AMCHP Conference.

Population-Based: CMS will sustain family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, NBHS Advisory Council, AMCHP Conference, and efforts to address integration of Medical Home. Family Organizations will be invited to provide input into CYSHCN Program activities during scheduled meetings.

Infrastructure Building: CYSHCN Program will sustain partnerships with family organizations, seeking input in all Program areas and involving them in decision-making. CMS will continue to meet with Family Organizations to discuss ways to improve upon efforts to ensure that families partner in decision-making at all levels and are satisfied with the services they receive. CMS Program will continue to contract with family organizations will support these efforts. The NBHS coordinator, who is also serving as Interim Program Manager for CMS, will continue to participate on the board of the Family to Family Health Information Center with PRO.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48	50	52	43	43
Annual Indicator	41.6	41.6	41.6	41.6	41.6
Numerator					
Denominator					
Data Source				http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm	http://mchb.hrsa.gov/cshcn
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	43	43	43	43	43

Notes - 2009
Please see notes from 2006 and 2007.

Notes - 2008
Please see notes from 2006 and 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Future performance objectives have been lowered to a more attainable level based on the most recent survey results.

a. Last Year's Accomplishments
July 2008-- June 2009
Direct: The CYSHCN Director provided guidance in the development of a peer-mentor program for the Navajo Nation which was slated to take place in FY '08 based on the Las Vegas model and was designed to assist YSHCN with transition from pediatric to adult care. This program was put on hold due to the loss of several key staff members and the troubled economy. The State implemented a hiring freeze in fall of 2008; therefore, these position remained vacant. Out of state travel was severely restricted, making implementation of this program even more difficult. The CMS social workers continued to attempt to connect clients to a medical home.

Population-Based: The Newborn Hearing and Newborn Genetic Screening Programs within CMS stressed inclusion of the medical home during follow-up when an affected infant was identified through screening.

Infrastructure Building: The Asthma summit was completed in 2009. Work continued with the Children's Cabinet in addressing the medical home concept and EPSDT compliance through the Early Childhood Action Committee. CMS and partners provided input regarding the Medical Home concept into the expanded Medicaid program and the State Health Plan. CMS unsuccessfully applied to HRSA for the Integrated Services grant which would have emphasized medical home and youth transition along with the six core performance measures.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Social Workers connect families with a Medical Home	X			
2. CMS Medical Director works with Pediatric Council to promote Medical Home		X		
3. Provide input on Medicaid redesign and state health plan			X	
4. Social workers assist families to fully partner with PCP within the Medical Home				X
5. Newborn Screening Programs include medical home in follow-up of identified infants				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities
July 2009--June 2010
Direct: CMS attempts to connect CYSHCN clients to a Medical Home, through the care coordination and transition services provided by social workers statewide. CMS social workers fax asthma action plans to the primary care provider and the school nurse after each asthma outreach clinic, providing a link to the Medical Home and wrap-around services.

Enabling Services: CMS social workers empower parents and youth to partner with their primary care provider in order to ensure their needs are met within the Medical Home.

Population-Based: The Newborn Hearing and Genetic Screening Programs continue to include the medical home during follow-up when an infant is identified through newborn screening. CMS continues Regional follow-up work (post-summit) on asthma protocols which emphasize linking with a medical home.

Infrastructure Building: The CMS Medical Director sits on the Pediatric Council of the NM Pediatric Society, where discussion of Medical Home is on-going. The Council is working with Medicaid and insurance companies to establish reimbursement for Pediatricians who provide care within a true Medical Home.
The Title V Program continues to contract with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision-making.

c. Plan for the Coming Year
July 2010 -- June 2011

Direct: CMS will continue the work of connecting CYSHCN clients to a Medical Home, through the care coordination and transition services provided by social workers statewide. CMS social workers will continue to fax asthma action plans to the primary care provider and the school nurse after each asthma outreach clinic, providing a link to the Medical Home and wrap-around services.

Enabling Services: CMS social workers will continue to empower parents and youth to partner with their primary care provider in order to ensure their needs are met within the Medical Home.

Population-Based: The Newborn Hearing and Newborn Genetic Screening Programs will continue to include the medical home during follow-up when an infant is identified through newborn screening.

Infrastructure Building: The CMS Medical Director will to continue to work with the Pediatric Council of the NM Pediatric Society on promoting the Medical Home concept. The Title V Program will continue to contract with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision-making.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62	70	70	59	59
Annual Indicator	56.6	56.6	56.6	56.6	56.6
Numerator					
Denominator					
Data Source				http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm	http://mchb.hrsa.gov/cshcn
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	59	59	59	59	59

Notes - 2009
Please see notes from 2006 and 2007.

Notes - 2008
Please see notes from 2006 and 2007.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
July 2008 -- June 2009

Enabling: Provided care coordination to approximately 5,200 CYSHCN and school-age children who are not Medicaid/SCHIP eligible. CMS CYSHCN Program provided assessment of insurance options for clients, and completed PE-MOSAA's to determine if the children or youth were eligible. Also the social workers assisted clients to enroll in NMMIP and LIPP and SCI if eligible.

Infrastructure Building: The CYSHCN Program enrolled 60 more children onto the NMMIP with an emphasis on children who have unmet orthopedic needs.

CMS continued to work with NMMIP to increase coverage for certain diagnoses.
The program continued its work with the Commission for the Deaf and the Commission for the Blind and Visually Impaired to improve services to children in these communities. CMS attended the Pediatric Council meetings to address the needs and improve the care of children with asthma in dialogue with Medicaid and the MCO's. CMS explored eligibility requirements and gaps in coverage under the multiple plans under Insure New Mexico. CMS worked with CTH to address the unmet needs of non-Medicaid eligible children and youth with orthopedic needs, and participated on the Medicaid Outreach Committee. Enrollment into SCI was frozen due to the economy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination to CYSHCN		X		
2. Expand coverage to children by enrolling onto NMMIP.				X
3. Work with the Commission for the Deaf and the Commission for the Visually Impaired to improve services to children in these communities				X
4. Continue work with the Pediatric Council to address coverage by Medicaid and the MCO;s for pediatric asthma				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Enabling: CMS social workers provide care coordination to approximately 5,200 CYSHCN who are not Medicaid/SCHIP eligible. CMS continues to provide assessment of insurance options for clients, and assist with PE-MOSAA's to determine if the children or youth are eligible. The social workers assist clients to enroll in NMMIP and LIPP and SCI if eligible.

Infrastructure Building: The CYSHCN Program has enrolled 53 more children onto the NMMIP this year to provide broad insurance coverage for this high cost population. The CMS Medical

Director is attending the Board Meetings of the NMMIP in order to stay abreast of changes due to the new federal health reform.
CMS continues to work with NMMIP to increase coverage for certain diagnoses. The program continues its work with the Commission for the Deaf and the Commission for the Blind and Visually Impaired to improve services to children in these communities. The CMS Medical Director attends the Pediatric Council meetings to improve the care of children with asthma in dialogue with Medicaid and the MCO's. The CMS program continues to be represented on the Advisory Board for the Family-to-Family Health Information Center at Parents Reaching Out, which is addressing insurance coverage for CYSHCN in the state. CMS continues to explore eligibility requirements and gaps in coverage under the multiple plans under Insure New Mexico.

c. Plan for the Coming Year
July 2010 -- June 2011

Enabling: CMS social workers will continue to provide care coordination to CYSHCN and school-age children who are not Medicaid/SCHIP eligible. CMS CYSHCN Program will continue to provide assessment of insurance options for clients, and PE-MOSAA's to determine if the children or youth are eligible, and the social workers assist clients to enroll in NMMIP and LIPP and SCI if eligible.

Infrastructure Building: The CYSHCN Program will continue to enroll more eligible children onto the NMMIP this year to provide broad insurance coverage for this high cost population. The CMS Medical Director will continue attending the Board Meetings of the NMMIP in order to stay abreast of any program changes.
CMS will continue to work with NMMIP to increase coverage for certain diagnoses. The program will continue its work with the Commission for the Deaf and the Commission for the Blind and Visually Impaired to improve services to children in these communities. The CMS Medical Director will attend the Pediatric Council meetings to improve the care of children with asthma in dialogue with Medicaid and the MCO's. The CMS program will continue to be represented on the Advisory Board for the Family-to-Family Health Information Center at Parents Reaching Out, which is addressing insurance coverage for CYSHCN in the state.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69	70	70	89	90
Annual Indicator	85.7	85.7	85.7	85.7	85.7
Numerator					
Denominator					
Data Source				http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm	http://mchb.hrsa.gov/cshcn
Check this					

box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	90

Notes - 2009
Please see notes from 2006 and 2007

Notes - 2008
Please see notes from 2006 and 2007

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
July 2008 -- June 2009

Direct: Care coordination provided by CMS staff. Maintain 127 specialty multidisciplinary specialty clinics statewide.

Population-Based: Program continues to work with partners to assure access to EPSDT to increase identification and referral to early intervention services.

Infrastructure Building: Title V Director is designee to the Children's Cabinet, ECAN and assists Children's Report Card. The Title V Director, CYSHCN Director, CMS FIT program work with key leaders from state agencies, parents, early intervention programs, medical providers/pediatricians, the ICC, regarding unmet EPSDT needs and plans resulting from the

Developmental Screening Symposium. The Newborn Hearing Coordinator participates in the D/HH Task Force to address needs of D/HH children. CMS collaborated with Environmental Epidemiology and convened the statewide asthma summit, a series of plans to action oriented meetings with key stakeholders from the public & private sector to create a comprehensive, multidisciplinary approach to pediatric asthma care for NM. Four regional meetings were held. A special follow-up meeting in Hobbs was held fall 08 in response to the high rates of asthma that was discovered. CMS recruited a new pulmonologist from Presbyterian who contracted with the program for 12 pulmonary clinics. Several of these clinics had been cut but were then reinstated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination to CYSHCN	X			
2. Sponsor 127 outreach specialty clinics statewide	X			
3. Continue work with partners to ensure EPSDT screening			X	
4. Provide representation to the Children's Cabinet and Early Childhood Action Network				X
5. Improve provision of services to children with asthma/asthma summit				X
6. Increase number of CYSHCN on NMMIP				X
7. Work with Secretary's office to address infrastructure for CYSHCN				X
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Direct: Continue care coordination which is provided by CMS staff and available to all CYSHCN and their families; strengthen linkages to early intervention services and the Part C program, increase child find activities with CYFD and pediatric practices; and provide 127 specialty multidisciplinary specialty clinics statewide. UNM Neurology hired an additional neurologist to assist in maintaining the number of clinics for next fiscal year. This year they had to cut 5 clinics due to staff shortages.

Population: CMS CYSHCN Program and the CMS FIT Program work with partners in efforts identified to address assurance of EPSDT screening for children/youth in order to increase the identification and early referral to early intervention services for children with or at risk for developmental delays.

Infrastructure: The Title V Director is a designee to the Children's Cabinet, and the MCH Program manager is now the Child Health Unit representative to the Early Childhood Action Network. The program places children onto NMMIP, the Non-Medicaid, Premium Assistance Program, resulting in coverage for almost all children in New Mexico. The $300,000 appropriation to CMS from the 2007 Legislature CMS was recurring in the budget but cuts to DOH General Fund appropriation will affect the program.

c. Plan for the Coming Year
July 2010 -- June 2011

Direct: Continue care coordination which is provided by CMS staff and available to all CYSHCN and their families; The CMS FIT program has been struggling to maintain statewide coverage due to hiring freeze. The program will be transitioning its remaining clients to early intervention providers. The CMS FIT social workers will be available to provide social work services and care coordination for CYSHC; and provide 127 specialty multidisciplinary specialty clinics statewide. The number of clinics will remain at FY 10 levels due to budget constraints.

Population-Based:
CMS CYSHCN Program will continue to work with partners in efforts identified to address assurance of EPSDT screening for children and youth in order to increase the identification and early referral to early intervention services for children with or at risk for developmental delays. The program will be available to provide care coordination for CYSHCN birth to three years of age.

Infrastructure Building:
The Title V Director will continue as a designee to the Children's Cabinet, and Carol Tyrell as the Child Health Unit representative to the Early Childhood Action Network. Ms. Peacock will continue to serve in an advisory capacity to the Secretaries of the Departments of Health, Human Services, Aging and Children, Youth and Families in her work with the Children's Cabinet. The program will continue to place children onto NMMIP and monitor the effects of the new health reform on access to care for CYSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	47	47	36	36
Annual Indicator	33.7	33.7	33.7	33.7	33.7
Numerator					
Denominator					
Data Source				http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm	http://mchb.hrsa.gov/cshcn
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average					

number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	36	36	36	36	36

Notes - 2009
Please see notes from 2006 and 2007.

Notes - 2008
Please see notes from 2006 and 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Future performance objectives have been lowered to a more attainable level based on the most recent survey results.

a. Last Year's Accomplishments
July 2008 -- June 2009

Direct: CYSHCN Social Workers provided service coordination and transition planning (involving youth) to youth aged 14-21 through the use of a "CMS Youth Transition Plan." This plan was designed to determine support systems - in place, available and needed -- as well as to elicit viability for plans, hopes and dreams for the future. Social workers assisted families in applying for insurance either through the State's high risk insurance pool or the State Coverage Insurance (SCI) to ensure health care coverage once clients age out of the Program.

Enabling: CMS administered an insurance assistance program by helping clients enroll in a high risk insurance pool, and by paying premiums and deductibles for qualifying clients enrolled in the New Mexico Medical Insurance Pool to give clients a head start on obtaining medical insurance once they transition out of the Program. Intense transition planning is done with clients at least 6 months before transitioning out of the Program to ensure that they are able to pay their insurance premiums.

Population Based: CMS participates in the Statewide Transition Coordinating Council along with numerous other State, public and private agencies. The Council has a focus on creating an infrastructure for communities to develop and improve transition services. CMS had contracted

with Abrazos Family Health Services to provide transition training and serve as advisors to the Program in a pilot project to take place in the Navajo Nation. Budget constraints prevented the Program from taking part in this project, so the contract was amended. CMS sponsored a Leadership Institute run by Abrazos. Participants at this conference were educated in several topics, including youth transition.

Infrastructure Building: The CMS Transition Team utilized evaluation surveys to assess policies used by CYSHCN Social Workers in transition planning with youth. The surveys solicited input from consumers and social workers. Review of surveys indicated that no major changes in policy were necessary at that time.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Transition planning services to youth age 14-21 through care coordination by 45 social workers to cover all 33 counties in New Mexico.	X			
2. Advocate for open door for interagency collaboration at State level to enhance cooperation at local level amongst professionals working with youth & families on all aspects of transition, through efforts of Statewide Transition Coordinating Council.			X	
3. MS Regional Transition liaisons review issues, resources, etc. to inform policies regarding transition-age CYSHCN				X
4. CMS staff assist families in applying for health care insurance	X			
5. CMS funds premiums/deductibles for qualifying YSHCN enrolled in New Mexico Medical Insurance Pool		X		
6. Use NM Behavioral Risk Factor Surveillance System, data for age 18-24 to monitor transition indicators				X
7. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance				X
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Direct: CYSHCN Social workers continue to provide service coordination and transition planning to youth aged 14-21 through the "CMS Youth Transition Plan." CMS social workers also help families apply for a high-risk insurance pool to ensure health care coverage once clients age out of the Program. Funding for the SCI Plan has been frozen, but clients can be put on a wait list should funding once again be available.

Enabling: CMS pays premiums and deductibles for qualifying clients enrolled in the NMMIP to give clients a head start on obtaining medical insurance once they transition out of CMS. Intense transition planning is done with clients at least 6 months before, including applying for a Low Income Premium Plan through the Pool.

Population Based: CMS continues membership in the Statewide Transition Coordinating Council (STCC), by attending meetings, sharing information between all represented agencies and collaborating on designated projects.

Infrastructure Building: CMS assessed its policies for CYSHCN Social Workers in transition planning with youth through evaluation surveys soliciting input from consumers and social workers. Clarity on transition planning with CMS clients enrolled in the NMMIP was added to the section on NMMIP in the CMS Manual of Operating Procedures and distributed to all staff.

c. Plan for the Coming Year
July 2010 -- June 2011

Direct: CYSHCN Social Workers will continue to provide service coordination and transition planning (involving youth) to youth aged 14-21 through the use of the "CMS Youth Transition Plan." Staff training will continue as needs arise. Staff will search avenues of obtaining health care insurance for clients aging out of the Program.

Enabling: Staff will pursue captioning (in English and Spanish) of an inspirational transition training video that was created several years ago. Once accomplished, it will be copied and distributed statewide and nationally along with its accompanying discussion guide. CMS will continue to fund premiums and deductibles for qualifying clients enrolled in the New Mexico Medical Insurance Pool to give clients a head start on obtaining medical insurance once they transition out of the Program.

Population Based: CMS will continue membership in the Statewide Transition Coordinating Council (STCC).

Infrastructure Building: CMS will review and update policy as necessary for use by CYSHCN Social Workers in transition planning with youth. Training needs specific to youth transition issues identified will continue throughout FY11. CMS Staff will receive regular updates and resource information on youth in transition through Regional Managers. The Transition Section of the CMS Policies and Procedures Manual will be updated and re-distributed to all staff.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73	73	78	82	82
Annual Indicator	78.4	76.2	81	79.1	79.1
Numerator					
Denominator					
Data Source				http://www.cdc.gov/vaccines/stats-surv/nis/tables/	http://www.cdc.gov/vaccines/stats-surv/nis/data/ta
Check this box if you cannot report					

the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	82	82	82	82	82

Notes - 2009
Immunization information is from the Centers for Disease Control and Prevention which presents data in percentage format rather than numerator/denominator format.

Source: CDC National Immunization Survey data from July 2008-June 2009.

Notes - 2008
Source: CDC National Immunization Survey data from July 2007-June 2008.
http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

CI: 8 %

Notes - 2007
Source: CDC National Immunization Survey data from July 2006-June 2007.
http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

CI: 5.4%

a. Last Year's Accomplishments
July 2007-June 2008

Enabling Services: Continued the Done by One (DBO) campaign, an outreach campaign that encourages providers and parents to get children immunized at the earliest possible opportunity. The New Mexico Done by One optimized childhood immunization schedule has several advantages: children are protected at a younger age; it is easier to give shots to children at a younger age; and it continues education for providers. All the shots are given at 2, 4, 6, and 12 months.

Population Services: At statewide events in During "Got Shots? Protect Tots!" weeks held in 2008 and 2009, participating providers opened their doors on one or more publicized dates and provided immunizations to any child who presented without an appointment, regardless of whether they are a patient or whether they have insurance. Most participating providers also had Presumptive and Medicaid Eligibility services available during the event.

Direct Services: Continued to provide immunization technical assistance to VFC sites through visits by contract nurses. These Immunization Consultants also provide immunization training in provider practices using the Child Health Immunization Learning Initiative (CHILI) presentation. CHILI is four-hour training on immunizations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Done by One schedule which allows for providers and parent to get children immunized at the earliest possible opportunity.		X	X	
2. “Got Shots? Protect Tots” statewide immunization events.	X		X	
3. Continue the Immunization Consultant technical assistance project	X	X		
4. The VFC program represents an approach to improving vaccine availability nationwide by providing vaccine free of charge to VFC-eligible children through public and private providers.	X		X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008--June 2009

Enabling Services: Continuing participation in the New Mexico Immunization Coalition Steering committee meetings.

Population Services: Ongoing "Got Shots? Protect Tots!" immunization days are being held during two weeks in 2008.

Direct Services: Continuing support for Immunization Consultant technical assistance. Providing CHILI trainings for VFC providers to improve vaccination policy, administration, and vaccine storage and handling among VFC providers. Conducted a randomized school survey of immunization levels in kindergarten and seventh grades.

Infrastructure Services:
VFC visits include an evaluation of each practice's immunization "best practices" and immunization coverage levels for a majority of practices. Coverage surveys use the clinical assessment software application (CoCASA). Immunization consultants provide immunization technical assistance and training in vaccine administration, storage and handling, and immunization best practices to New Mexico VFC providers.

c. Plan for the Coming Year
July 2009-June 2010

Enabling Services: Continue participation in the monthly meetings of the New Mexico Immunization coalition Steering Committee. Continue the Done by One Initiative.

Direct Services: [See "Got Shots? Protect Tots," section also see http://hsc.unm.edu/programs/nmimmunization/gotshots.html for more info. Continue Immunization Consultant technical assistance, promote Done by One schedule, and CHILI trainings for VFC providers.

Infrastructure Services: Continue VFC site visits.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	35	34.5	33	33
Annual Indicator	35.7	34.3	34.3	34.3	34.3
Numerator	1619	1592	1592	1592	1592
Denominator	45303	46453	46453	46453	46453
Data Source				New Mexico Vital Records	New Mexico Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	33	33	33	33	33

Notes - 2009
2008 natality data not yet available.

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 Natality data is not yet available.
2007 BBER population estimates are not yet available.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population

estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

a. Last Year's Accomplishments
July 2008 -- June 2009

Direct: In 2009, the total number of adolescents aged 15-17 seen at statewide family planning clinics for comprehensive reproductive health services was 6635; 5999 females and 636 males.

Enabling: Local Public Health Offices (PHOs) provided education and outreach for clients aged 15-17 at schools, detention centers, and community centers on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually-transmitted infections (STI). The NM DOH Family Planning Program (FPP) provided technical assistance and oversight for the South Valley Male Involvement Project in Albuquerque to promote male involvement in reproductive health with educational services to increase young men's knowledge and skills in addressing their reproductive health needs and outreach to promote male clinical services.

Population-Based: The FPP and the NMTPC continued to recommend four population-based strategies (comprehensive sex education, service learning programs, adult-teen communication programs and male involvement programs), which have worked in concert with the clinical family planning direct services to prevent teen pregnancy.
Comprehensive sex education emphasizes abstinence as the best method for avoiding unintended pregnancy, but also teaches about condoms and contraception. Service learning programs promote healthy behavior and successful achievement in school through community-based volunteer service and curriculum-based learning. Adult-teen communication programs give adults information and opportunities to communicate effectively with young people about reducing risky sexual behavior. Effective male involvement programs target boys and young men with programs that include community service or other out-of-school activities and a cultural component.
The FPP has continued evidence-based education programs at 19 sites in 10 counties with an increase in the number of teens reached. This school and community- based programming includes experiential education and service learning, which has been proven effective nationally. There was an increase of 220 teens, for a total for 715, who participated in evidence-based adolescent pregnancy prevention programming. The majority (585) were in TOP, the main focus for educational services. TOP, a service learning program designed to prevent teen pregnancy and academic failure combines curriculum-guided experiential activities and discussion plus community service work. The FPP supports 17 TOP sites in 10 counties. Two other comprehensive sex education programs include peer education and service learning.
The South Valley Plain Talk program has completed the first two phases of the Plain Talk program, community mapping and community outreach. Community mapping is now being repeated to measure the effect of the community outreach phase with walkers and talkers (promotoras) conducting home health parties. The Doña Ana County program in Mesquite and Vado continued with the second phase with home health parties in the community. Topics covered at the home health parties include reproductive anatomy, birth control, STD transmission and communication.

The number of TOP projects as part of the collaboration with Elev8, a statewide initiative of the NM Community Foundation, increased from 4 to 7 in 2009. The demonstration phase is being implemented over four years in five diverse middle schools (MS): Gadsden MS; Laguna MS (Pueblo of Laguna); the Native American Community Academy (an Albuquerque charter school); and Grant and Wilson MSs (in Albuquerque). NM DOH and NM FPP provide support through the SBHCs and the TOP as one of the extended-day programs. The components of Elev8 New Mexico are: Extended-Day Learning (EDL), Comprehensive School-Based Health and Key Family Supports and Services.

Infrastructure Building: Challenge 2010, a project of the FPP and the NMTPC, asks counties to reduce teen births by 15% from 2006-2010. In 2008, the third year of Challenge 2010, 4 counties reduced birth rates to 15-17 year olds by at least 9%. Challenge 2010 provides data on both 15-17 year olds and 15-19 year olds to focus attention on birth rates for both groups in each county. The 2008 Challenge pamphlet focused on tips for adult teen communication strategies that positively affect teen pregnancy prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Comprehensive reproductive health clinical services will be provided to clients aged 15-17 at PHOs and clinical contractor sites.	X			
2. PHOs will provide education and outreach for teens aged 15-17 at schools, detention, and community centers on reproductive health topics.		X		
3. The FPP will provide technical assistance and oversight for the male involvement in reproductive health project.		X		
4. The FPP will fund and support evidence-based community education programming such as TOP.			X	
5. The FPP will support “Plain Talk” a neighborhood-based initiative to help adults, parents and community leaders to communicate effectively with young people about reducing adolescent sexual risk-taking			X	
6. The FPP will evaluate evidence-based community education programming.				X
7. The NM DOH will track teen birth rates and other relevant health indicators on the State Indicator-Based Information System (IBIS).				X
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Direct: Teens are considered a hard-to-reach population. The statewide FPP-funded clinics offer confidential family planning services including initial contraceptive dispensing by nurses guided by a protocol, after which clients are given an appointment for a detailed clinic visit with a clinician within 3 months.

Enabling: PHO staff's education and outreach activities in the counties with high teen birth include 1) A CNP facilitated a Q&A discussion among TOP participants and their parents at Deming Mid-High School. The discussion included STI, birth control and the importance of making informed decisions. This opened up sexual issues communication between the students and their parents. 2) A health educator presented on STI to over 189 students in lieu of Sex Education Week at Portales High School. A nurse also spoke to the same students regarding birth control, alcohol, tobacco, drugs, violence prevention, STI, and teenage pregnancy.

The SVMIP staff provide peer health education at local middle and high schools. Alamosa PHO and SVMIP staff are working as a team to increase outreach to males and their partners. At Alamosa PHO, walk-in young men may have one-on-one educational counseling with SVMIP

staff. In collaboration with local primary care clinics, they also provide outreach clinical services at local SBHCs.

Population-Based: FPP continues its collaboration in delivering TOP and Plain Talk in communities statewide.

c. Plan for the Coming Year
July 2010 -- June 2011

Direct: The statewide FPP-funded clinics will continue to provide confidential, comprehensive reproductive health services to teen clients aged 15-17 at approximately 120 PHOs and clinical contractor sites. Clinical services include pregnancy testing, providing a contraceptive method including emergency contraceptive pills and/or a clinical exam visit. The clinical exam visit includes: a medical history/physical, laboratory tests (including Pap smear), STI testing and counseling, family planning counseling, and a supply of a contraceptive method of choice. Over 20 sites offer confidential family planning services with expanded hours to accommodate teens.

Enabling: PHO staff will continue to provide education and outreach for clients aged 15-17 at school and community-based locations.

Population-Based: The main focus of the FPP teen pregnancy prevention program is implementing evidence-based programs that are culturally and developmentally appropriate for teens. The FPP will continue to partner with community-based organizations and other State agencies to apply for more federal funding in order to expand population-based programming, particularly for TOP and ¡Cuídate! (Take Care of Yourself). ¡Cuídate! is a small-group, culturally-based intervention to reduce HIV sexual risk among Latino youth. It incorporates salient aspects of Latino culture, including familialism (i.e., the importance of family) and gender-role expectations (i.e., machismo, which is described as the man's responsibility in caring for and protecting one's partner and family). These cultural beliefs are used to frame abstinence and condom use as culturally accepted and effective ways to prevent STI, including HIV. Through the use of role plays, videos, music, interactive games and hands-on practice, ¡Cuídate! addresses the building of HIV knowledge, understanding vulnerability to HIV infection, identifying attitudes and beliefs about HIV and safe sex, and increasing self-efficacy and skills for correct condom use, negotiating abstinence, and negotiating safer sex practices. The intervention curriculum is available in English and Spanish.

Infrastructure Building: The FPP contracts with a group of independent evaluators to assess the impact of TOP implementation among statewide participants. The NM DOH tracks teen birth rates and other relevant health indicators on the State Indicator-Based Information System (IBIS).

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48	48	50	50	50
Annual Indicator	48	48	48	48	48
Numerator					
Denominator					
Data Source				NM Office of Oral Health	NM Office of Oral Health

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
1,783 third graders were given sealants by the NM Department of Health's Oral Health program.

The 2007 National Survey of Children's Health found that 91.6 % of children aged 6-11 had no unmet need for oral health care. 89.2% in that age group had one or more preventive care visits during the past 12 months.

Notes - 2008
This is a rough estimate; no surveillance was done in this year. The dental program reported the same level of effort, hence the same estimated level of coverage. This coverage is among children enrolled in schools with a high proportion of children on the free or subsidized meal program

The 2007 National Survey of Children's Health found that 91.6 % of children aged 6-11 had no unmet need for oral health care. 89.2% in that age group had one or more preventive care visits during the past 12 months.

Notes - 2007
This is a rough estimate; no surveillance was done in this year. The dental program reported the same level of effort, hence the same estimated level of coverage. This coverage is among children enrolled in schools with a high proportion of children on the free or subsidized meal program

The 2007 National Survey of Children's Health found that 91.6 % of children aged 6-11 had no unmet need for oral health care. 89.2% in that age group had one or more preventive care visits during the past 12 months.

a. Last Year's Accomplishments
Last Year's Accomplishments

Direct Services
The NM Office of Oral Health (OOH) has partnered with public school based and private school providers to increase the number of children receiving preventive dental sealants and treatment services. OOH is continuing its efforts to work with the NM Dental Board, NM Health and Humans Services Department, the NM Oral Health Council, the legislature, and associations to increase access for dental care. OOH continues to support public-private partnerships with the hope of increasing dental services to lower income children.

OOH continues to use general and federal funds to support low-income children who do not qualify for Medicaid but are in need of preventive and treatment services. OOH also continues to use general funds to support the ongoing dental sealant program. In FY 2009, 6,091 third grade children received dental sealants totaling 18,770 teeth sealed. 43% of all third grade children received protective sealants on at least one permanent molar tooth.

Enabling Services
The NM OOH is working with The Human Services Dept. (HSD) to increase the number of children enrolled in Medicaid, promote access to dental services, and increase the number of Medicaid dental providers.

Population Based Services
The estimate for the number of dentists in New Mexico ranges from 32.4 to 43.7 per 100,000 populations. This is well below the national rate of 63.6 per 100,000 populations. The dentists in New Mexico are not evenly districted. Approximately 50 -- 60% of the dentists in the state practice in NE Albuquerque, which is a metro area, as compared to the remainder of New Mexico which is rural/frontier. 3 counties do not have a dentist. Access to dental care is limited in New Mexico and can be attributed to the lack of dentists in the state, low reimbursement by Medicaid, and low incomes of many New Mexicans, which results in large populations without dental insurance.

Infrastructure Services
OOH continued to work with the NM Oral Health Council and supported the action items developed by the former Governor's Oral Health Council to increase oral health awareness, expand the scope of practice for dental hygienists, and revamp the NM Dental Health Care Board regulation to increase the number of providers serving the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH promotes the application of dental sealants for 3rd grade children.	X			
2. DOH conducts a school based dental sealant program throughout the state.	X			
3. NMDOH FY10 Strategic Plan System Objective 3: Create an oral health system that provides children, low-income rural populations and people with disabilities with preventive and restorative oral health services.	X			
4. dental hygienists can place dental sealants		X		
5. Office of Oral Health provides direct services and contracts with providers to ensure the delivery of services			X	
6. Dental case manager pilot project implemented and a number of 3rd graders participated in the project.			X	
7. Increased partnership with non-state program offering same services to target 3rd grade children and data collection.				X
8.				
9.				
10.				

b. Current Activities
Current Activities

Direct Services
The OOH staff conducts a school based dental sealant program. OOH provides this service to over 125 schools participating in the Federal Free or Reduced School Lunch Program.

Enabling Services
OOH and the Family Health Bureau, Children's Medical Services (CMS) jointly provide a dental case management program to eligible low income and non-insured participating children in Rio

Arriba County and Santa Fe County.
Population Based Services
OOH coordinates the New Mexico Oral Health Surveillance Advisory Committee (NMOHSSAC). The Committees is responsible for conducting surveys, collecting dental data and analyzing oral health data. The information obtained identifies the oral health status of New Mexicans. The information is used by the State, local government, and the Legislature in the development and funding of oral health services.

Infrastructure Building Services
OOH contracts with a number of dental providers throughout the State to provide dental preventative and treatment services to low income and non-insured New Mexicans. The services provided include providing dental sealants, fluoride varnish, and treating dental diseases. OOH coordinates the New Mexico Oral Health Surveillance Advisory Committee (NMOHSSAC) which is responsible for conducting surveys, collecting dental data and analyzing oral health data.

c. Plan for the Coming Year
Plan for the Coming Year

Low income and non-insured children participating in Head Start, WIC, Families First and Cleft Palate programs will receive oral health education, dental screenings, fluoride varnish applications and the services of the dental case manager. (Santa Fe and Rio Arriba Counties have the services of a dental case manager). Parents will receive oral health education training (nutrition, dental hygiene, and injury prevention). The budget for oral health services in fiscal year 2011 remains the same as fiscal year 2010.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.5	6.9	6.9	7.5	6
Annual Indicator	6.6	8.0	6.4	6.4	6.4
Numerator	27	33	26	26	26
Denominator	409523	411065	405808	405808	405808
Data Source				NMVRHS analysis by MCH Epi	MVRHS analysis by MCH Epi
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	5	5	5	5

Notes - 2009
2008 and 2009 mortality data are not yet available.

Please note that the annual performance objective for 2008 should be "6"

Notes - 2008
2008 Mortality data is not yet available.

Please note that the annual performance objective for 2008 should be "6"

Notes - 2007
Source:

Numerator: NMVRHS
Denominator: BBER

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

a. Last Year's Accomplishments
July 2008 - June 2009

Enabling: The New Mexico SAFE KIDS Coalition (NMSKC) had no direct funds to purchase car seats or helmets, instead consulting with chapters and coalitions on fundraising and volunteer recruiting strategies. This included collaborating with the New Mexico Trauma Authority to distribute their funds appropriated annually by the NM Legislature. These funds were directed to the SAFE KIDS network of coalitions and chapters affiliated with designated trauma centers. The communities participating included Albuquerque, Santa Fe, Alamogordo, Farmington, Carlsbad, Lovington and Roswell. The NMSKC also increased its collaboration with NMDOT, PED, CYFD and many other agencies or nonprofits to implement both the Booster Seat Law of 2005 and Child Helmet Safety Act of 2007 statewide in virtually every community, regardless of size.

Population: Continued constant scheduling of press releases, brochure distribution, media interviews and promotions, and other social marketing opportunities for promoting of safe driving principals, including proper installation of car seats, importance of booster seats for even older children if they are too small for adult seat belts, always wearing a seatbelt as an example to all children, and making sure every occupant is secured in a motor vehicle at all times.

Infrastructure: A statewide New Mexico SAFE KIDS Coalition budget, funded by the Children's Cabinet, was not be introduced at the 2009 Legislature because of lack of funding. The intent was to provide a permanent state allocation of $100,000 - $300,000 to purchase and distribute child car seats, non-motorized vehicle helmets, and smoke alarms for events produced by SAFE KIDS coalitions and chapters. A portion of the funding was to be used to train home inspectors for the new First Born program, which provides 6-12 home visits per year for two years to new parents. A $150,000 grant proposal to the New Mexico Automobile Dealers Association for a similar project was also rejected due to the collapse of the automobile sales market, and the subsequent lack of grant funds available.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Expand network of SAFE KIDS chapters with support from statewide coalition and collaboration with nonprofits				X
2. Strengthen relationship with Safer New Mexico Now to advocate for informed policy-making, provide education, support law enforcement, offer resources, and nurture public understanding.			X	
3. Continue to support the Regional Early Care Education Conference (RECEC) collaborates to strengthen the ties between State and community agencies dealing with the health and safety of the child care environment.		X		
4. ursue additional funding mechanisms to finance SAFE KIDS programs statewide.			X	X
5. Continue to expand the relationships with the many nonprofits currently contracting with CYFD to provide home visitation services for new parents		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Enabling: The NM SAFE KIDS state coalition manages a network of 12 coalitions and chapters statewide. In collaboration with the nonprofit Safer New Mexico, over 100 car seat check and installation events are produced statewide on an annual basis, in addition to constant social marketing and distribution of brochure information regarding car seats, booster seats, seat belts & safe driving in every community.

Population: Continued constant scheduling of press releases, brochure distribution, media interviews and promotions, and other social marketing opportunities for promoting of safe driving principals, including proper installation of car seats, importance of booster seats for even older children if they are too small for adult seat belts, always wearing a seatbelt as an example to all children, & making sure every occupant is secured in a motor vehicle at all times.

Infrastructure: We are soliciting donations & volunteers to start new SAFE KIDS chapters in Taos & Rio Arriba Counties. New Mexico offers 16 mini-conferences per year to home daycare providers so that they can comply with certification requirements.
Upon their invitation, we also expanded home safety workshops to include the Region 6 Head Start Conference for five states, the Albuquerque Area Early Head Start program, & the regional Native American Head Start programs, in addition to the first annual Home Visiting Specialists Conference for CYFD & workshops for Public Health Office employees.

c. Plan for the Coming Year
July 2010 -- June 2011

Enabling Services: In a continuing effort to encourage parents NOT to remove car seats from the secured position in the automobile to transport their children elsewhere, we will be increasing our promotion of the use of portable cribs. Eventually our SAFE KIDS goal is to make sure that every newborn leaves the hospital with both a car seat and a portable crib, as each will assist in the use of the other.

Population Services: Continued constant scheduling of press releases, brochure distribution, media interviews and promotions, and other social marketing opportunities for promoting of safe driving principals, including proper installation of car seats, importance of booster seats for even older children if they are too small for adult seat belts, always wearing a seatbelt as an example to all children, and making sure every occupant is secured in a motor vehicle at all times.

Infrastructure Services: We are soliciting donations and volunteers to start new SAFE KIDS chapters in Taos and Rio Arriba counties this coming year, as well as to expand the current SAFE KIDS chapters in Gallup and Grants. This will take place in conjunction with the car seat events, as well as the skate park campaign, bicycle rodeos and other helmet safety events.

If there is sufficient funding, the home safety program will be expanded from home day care providers to foster, adoptive, and grandparents, of which there are approximately 100,000 currently residing in New Mexico.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		70	50	43	45
Annual Indicator	68	44.3	41.8	41.8	42.2
Numerator					
Denominator					
Data Source				http://www.cdc.gov/BREASTFEEDING/DATA/NIS_data/ind	http://www.cdc.go
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45	45	45	45	45

Notes - 2009
42.2% is the percent of infants that were fed any breast milk to six months or beyond. This is the result fromthe National Immunization Survey of children born in 2006.

The percent of infants from that same cohort that were exclusively breastfed was 33.2% at three months, and 14% at six months.

Healthy People 2010 goals for exclusive breastfeeding are 60% at three months and 25% at six months.

Source: http://www.cdc.gov/breastfeeding/data/NIS_data/ind

Notes - 2008
41.8% is the percent of infants that were fed any breast milk to six months or beyond. This is the result from the 2007 National Immunization Survey of children born in 2005.

CI: 8.4%

The percent of infants from that same cohort that were exclusively breastfed was 37.2% at three months, and 15% at six months.

Healthy People 2010 goals for exclusive breastfeeding are 60% at three months and 25% at six months.

Source: http://www.cdc.gov/breastfeeding/data/NIS_data/data_2004.htm

Notes - 2007
41.8% is the percent of mothers that breastfed their infants any breast milk to six months or beyond. This is the result from the 2007 National Immunization Survey of children born in 2005. The number is provisional and the final number will be available in August, 2009.

The provisional percent of mothers that exclusively breastfed their infants, according to this same survey, was 37.2% at three months, and 15.0% at six months. Healthy People 2010 goals for exclusive breastfeeding are 40% at three months and 17% at six months.

Source: http://www.cdc.gov/breastfeeding/data/NIS_data/data_2004.htm

a. Last Year's Accomplishments
Direct: UNM and Presbyterian Hospitals in Albuquerque operated free Lactation Clinics that provided postpartum breastfeeding consultations and breastfeeding classes monthly. 3 hospitals in NM banned the dissemination of formula gift packs to mothers upon hospital discharge. WIC provided group breastfeeding support sessions and individual counseling to pregnant and breastfeeding mothers; a choice between 4 different types of breast pumps for breastfeeding mothers; and other breastfeeding aides and devices as needed by high-risk breastfeeding mothers. WIC also provided prenatal backpacks filled with support materials to all pregnant

mothers.

Enabling: WIC continued operation of the WIC Peer Counselor Program; expanded to 34 sites and 45 peer counselors.

Population-Based: The NM BFTF and WIC worked to increase public acceptance of breastfeeding through the development and dissemination of 6,000 "Positive Images of Breastfeeding" 2009 Calendars to families and healthcare providers statewide; created public awareness of breastfeeding through WIC Clinic and BFTF celebrations for World Breastfeeding Week, August 1-7, 2009. WIC continued the TV fathers' involvement media campaigns. The 2009 NM Legislative Session passed a House Memorial to appoint a task force to assess breastfeeding support NM student-mothers receive.

Infrastructure Building: WIC continued work on computer system to improve data collection for tracking client breastfeeding duration; provided breastfeeding training for health care professionals through: 7 WIC new employee "Breastfeeding Basics" workshops; the NM BFTF Annual Advanced Concepts in Breastfeeding Conference; Mother Journey's Lactation Educator Course; an IBLCE Exam Prep Course; and 3 Loving Support Peer Counselor Trainings. WIC and the NM BFTF continued the project "Using Loving Support to Build a Breastfeeding Friendly Community" in Grants which included presenting health care professional training and assessment of community needs. The NM BFTF awarded 2 mini-grants for breastfeeding duration projects to 2 local BFTF coalitions. Valencia County WIC/BFTF and Eddy County WIC/BFTF continued providing breastfeeding resources to local health care providers through the WIC funded Physician Outreach Project. Access for healthcare professionals to adequate breastfeeding research, supplies and resources continued through development of WIC's intranet and internet websites, and the BFTF website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC Breastfeeding Education and Counseling	X			
2. WIC Breastfeeding Peer Counseling		X		
3. WIC and BFTF Website Education and Activities				X
4. Annual Breastfeeding Continuing Education/Trainings for healthcare professionals				X
5. BFTF and WIC World Breastfeeding Week Celebration			X	
6. WIC Breastfeeding Media Campaign			X	
7. "Using Loving Support to Build a Breastfeeding Friendly Community" Model				X
8. BFTF Mini-Grants for Breastfeeding Projects Statewide.				X
9. UNM and Presbyterian Hospitals' Lactation Clinics	X			
10. NM Legislation in Support of Breastfeeding			X	

b. Current Activities

Detailed information about breastfeeding promotion in NM is available on WIC's website: www.nmwic, and the NM BFTF website: www.breastfeedingnewmexico.org

Direct: 9 hospitals in NM banned the dissemination of formula gift packs to mothers upon hospital discharge. WIC continues to provide resources, aides and breastfeeding support sessions to WIC mothers, as well as new food packages supporting exclusive breastfeeding.

Enabling: WIC increased number of peer counselors to 49 throughout 34 WIC clinic sites.

Population-Based: 6,500 "Positive Images of Breastfeeding" 2010 Calendars were given out statewide. WIC and NM BFTF participated in World Breastfeeding Week. As a result of House Memorial 58 passed by the NM 2009 Legislature, the Governor's Women's Health Office convened a task force which made recommendations for breastfeeding accommodations in schools to a legislative committee.

Infrastructure Building: Breastfeeding education and training opportunities for health care professionals continue to be provided through: WIC "New Food Rule" and "Breastfeeding Basics" trainings, the NM BFTF Annual Advanced Concepts in Breastfeeding Conference, and the Loving Support Peer Counselor Trainings. WIC posted a public internet site to include breastfeeding education. The project "Using Loving Support to Build a Breastfeeding Friendly Community" developed a weekly mothers' support group in Grants, and expanded to Clovis, NM.

c. Plan for the Coming Year

Indicator Data: Track baseline breastfeeding duration at infant's 6th month by June 2011. WIC will increase percentage of infants that are still breastfed at six months by three percentage points each year 2010 through 2012.

Direct: The NM BFTF will implement the NM BFTF Honor Roll Project to formally recognize hospitals in New Mexico that ban formula discharge bags with a plaque and ceremony. WIC will continue to provide a prenatal backpack filled with a book, DVDs, father and grandparent pamphlets and other breastfeeding support materials to all pregnant mothers; group breastfeeding support sessions and individual counseling to pregnant and breastfeeding mothers; increased emphasis on exclusive breastfeeding through the new food package; 4 different types of breast pumps; and other breastfeeding aides and devices as needed by high-risk breastfeeding mothers.

Enabling: WIC will continue to expand the services peer counselors provide through increasing the number of hours peer counselors spend supporting mothers in the WIC clinic setting; will increase peer counselor pay to enable better recruitment and retention of peer counselors; will expand peer counselor services to additional WIC clinics.

Population-Based: BFTF and WIC will continue the development and dissemination of "Positive Images of Breastfeeding" Calendars annually through WIC and other health care providers statewide. Public awareness of breastfeeding through WIC Clinic and BFTF celebrations for World Breastfeeding Week will take place, and will include a health care provider outreach WIC project to educate local hospitals and physician's. WIC will continue the TV media campaigns through development of 3 new TV commercials educating the public and the new breastfeeding/workplace law. The NM BFTF will lobby the NM legislature to amend the workplace law to include schools..

Infrastructure Building: WIC will begin tracking and continue analyzing client breastfeeding duration data through WIC and PRAMS data. Breastfeeding education and training opportunities for health care professionals will continue to be provided through WIC "Grow and Glow" and "Breastfeeding Basics" training, the NM BFTF Annual Advanced Concepts in Breastfeeding Conference, a Lactation Educator Specialist Course and the Loving Support Peer Counselor Trainings. Access for healthcare professionals to adequate breastfeeding research, supplies and resources will continue through on-going updates to the WIC staff's intranet site and the BFTF website. Development of local community breastfeeding projects to increase the duration of breastfeeding will continue through NM BFTF mini-grant funds. The number of IBCLCs in New Mexico will continue to be increased through providing NM BFTF scholarships for IBCLC exam expenses, and providing WIC staff with study resources. WIC and the NM BFTF will continue the "Using Loving Support to Build a Breastfeeding Friendly Community" Project in Clovis, NM.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95.5	95.7	96	96	96
Annual Indicator	92.3	92.3	92.3	60.8	49.8
Numerator	26616	27625	27625	18061	13678
Denominator	28822	29918	29918	29716	27492
Data Source				Children's Medical Services Program	Children's Medical Services Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	96	96	96	96	96

Notes - 2009
Screening rates appear lower than they are. The hearing screen field on the electronic birth certificate is not required, and many hospital personnel do not record this information, especially in larger birthing facilities.

Notes - 2008
Screened: 18061

Unknown/Missing: 11654

Infant died/parents declined: 1

Screening rates appear lower than they are. The hearing screen field on the electronic birth certificate is not required, and many hospital personnel do not record this information, especially in larger birthing facilities. NMVRHS is pursuing a change in regulation that would require that hearing screening status be recorded on the birth certificate.

Notes - 2007
Please see note from 2006.

a. Last Year's Accomplishments
July 2008 -- June 2009

Enabling: The program hired a short term follow-up coordinator, centralizing the process based on the successful model used by the genetic screening program. CMS social workers continue to provide long term care coordination, linkage to medical home, family support services.

Population-Based: Coordinator met regularly with NMSD and the CDHH to address lack of access to audiology services and now DOH Secretary. New case management, tracking and surveillance database was implemented.

Infrastructure Building: NBHS was awarded three years of HRSA funding and three years of CDC funding which resulted in program restructuring. Advisory Council meets to improve follow-up activities, maintain consistent policies. Coordinator continues as chair of CDC/ EHDI Diversity Committee, to address access issues for minorities. Case management mapping and data collection system development was implemented for Jan 2009. CMS monies for non-Medicaid D/HH children were used to purchase screening equipment for Early Intervention providers. The Coordinator worked with UNM telehealth program, Utah State, the Navajo Nation and Rehoboth McKinley Hospital in Gallup to initiate a audiology telehealth project in the Gallup region. Training provided to midwives and hospitals as needed this year in collaboration with the Metabolic Screening program. CMS continued involvement with D/HH task force and Hands and Voices.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Training of all hospital staff on proper procedure and protocol in collaboration with the Newborn Genetic Screening program and Vital records				X
2. Monitor compliance with reporting requirements				X
3. Enhance data collection system within Family Health Bureau				X
4. Implement audiology training practicum			X	X
5. Facilitate advisory council meetings				X
6. Facilitate EHDI Diversity Committee				X
7. Implement audiology telehealth project				X
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Enabling: The program works with short term follow-up coordinator to reduce lost to follow-up rates. Supplemental funding from HRSA used to contract with Education of Parents of Indian Children with Special Needs (EPICS) to improve outreach and education to Native American families with children that are deaf or hard of hearing.

Population-Based: Coordinator continued to address lack of access to audiology services. Supplemental funding from HRSA used to provide technical training to audiologists on diagnostic procedures.

Infrastructure Building: Maintain number of birthing hospitals providing universal screening at 100%. Hospitals received revised referral form and DVD curriculum developed by NCHAM to assist with on-going training needs. Continued NHS Advisory Council with a focus on improving follow-up activities. Policy revised for infants with risk factors. Coordinator continues to chair CDC EHDI Minority Committee, which addresses access for minorities. Maintain distribution of family materials including informational brochures and family handbooks in English and Spanish. Monitor compliance with the Public Health reporting requirements where medical providers are to report to DOH suspected and/or confirmed hearing loss in children birth to 4 years. Implemented telehealth audiology project in Gallup.The coordinator participates on the D/HH Task Force and

as a Board Member for Hands and Voices to improve service delivery for families.

c. Plan for the Coming Year
July 2010 -- June 2011

Enabling: The program will continue to work with the short term follow-up coordinator to improve follow-up by reducing time between first contact and discharge from hospitals and centralizing procedures. CMS social workers will continue to provide long term care coordination, linkage to medical home, family support services. Supplemental funding from HRSA will be used to continue to contract with Education of Parents of Indian Children with Special Needs (EPICS) to improve outreach and education to Native American families who have children that are deaf or hard of hearing.

Population-Based: Coordinator will continue o meet with NMSD to address lack of access to audiology services. Enhance new case management, tracking and surveillance database. Supplemental funding from HRSA will be used to provide technical training to audiologists on diagnostic procedures utilizing video conferencing and hands on practical experience at the annual meeting Fall 2010.

Infrastructure Building: Maintain the number of birthing hospitals that provide universal screening at 100%. . Continued to provide training and technical assistance to hospital providers, midwives and CMS staff to improve loss to follow-up. Enhance the use of a statewide data collection system to track referral and follow-up information in partnership with Vital Records, Birth Defects, Metabolic Screening program. Continued the Newborn Hearing Screening Advisory Council with a focus on improving follow-up activities. Implement revised policy on follow-up for infants with risk factors and maintaining consistent policies for screening. Coordinator will continue to participate and chair CDC sponsored EHDI Minority Committee, which is addressing access issues for minorities. Maintain distribution of family materials including informational brochures and family handbooks in English and Spanish. Monitor compliance with the Public Health reporting requirements established whereby medical providers are mandated to report to DOH suspected and/or confirmed hearing loss in children birth to 4 years. Implement Telehealth audiology pilot project in the Northwest now that diagnositic procedure is available.
The coordinator will continue to participate in the D/HH Task Force and as a Board Member for Hands and Voices to continue to strive for improvements on service delivery for families.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	10	10
Annual Indicator	9.8	9.8	11.9	11.9	11.9
Numerator	52160	52250	58681	58681	58681
Denominator	532241	535705	493459	493459	493459
Data Source				2007 National Survey of Children's Health	2007 National Survey of Children's Health
Check this box if you cannot report the numerator because 1.There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	10

Notes - 2009
Source:
National Survey of Children's Health
http://nschdata.org/Content/#

NM has reset its target to 10 for period 2004 through 2010; it is not reasonable to set it lower - the state should be able to maintain ground if present priorities remain actively pursued.

Notes - 2008
Source:
National Survey of Children's Health
http://nschdata.org/Content/#

NM has reset its target to 10 for period 2004 through 2010; it is not reasonable to set it lower - the state should be able to maintain ground if present priorities remain actively pursued.

Notes - 2007
Source:
National Survey of Children's Health
http://nschdata.org/Content/#

NM has reset its target to 10 for period 2004 through 2010; it is not reasonable to set it lower - the state should be able to maintain ground if present priorities remain actively pursued.

a. Last Year's Accomplishments
July 2008 -- June 2009

Direct: Family Health Bureau (FHB) staff participated in the EPSDT-Medicaid Advisory Committee. FHB worked with partners to identify statewide strategies to address issues of uninsured or underinsured, lead screening, and immunizations schedules and issues. Families FIRST and CMS programs completed PE/MOSAA applications for eligible pregnant women, children or youth. Medicaid continued to have a twelve-month renewal process. DOH is working collaboratively with HSD to identify community events that provide opportunities for outreach and Medicaid enrollment of eligible children.

Enabling: Title V MCH and State General funds were used to cover services to pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of health care coverage.

Infrastructure Building: About 21,000 children, 5 yrs old and under are uninsured in New Mexico. Human Services Division's increased the amount of income that can be disregarded and the amounts that can be deducted from gross income, thereby increasing the number of families who qualify for Medicaid. The Medicaid 1115 waiver continued to provide family planning services. Gaps in services were monitored and identified thru the Early & Periodic Screening, Diagnosis, & Treatment (EPSDT)-Advisory Committee. DOH worked collaboratively with the Children's Cabinet

to address universal coverage for children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the EPSDT-Medicaid Advisory Committee	X			
2. FHB will work with partners to identify statewide strategies to address issues of uninsured or underinsured.	X			
3. Families FIRST and CMS programs will provide assessment of insurance options for clients, and complete PE/MOSAA applications for children or youth who are eligible.	X			
4. Working collaboratively to the birth certificate requirement.	X			
5. Title V MCH and State General funds are being used to cover services to pregnant women and children who have no other source of coverage.		X		
6. Continue to reach out to families to increase the number of children who enroll for Medicaid and provide information to families about the new program which will provide assistance to pay for health insurance.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Direct: Family Health Bureau (FHB) staff is a member of the EPSDT-Medicaid Advisory Committee which meets quarterly to discuss services provided to children under EPSDT. PE/MOSAA training for CMS and Families FIRST (FF) staff continues and online training is being made available. This increases the number of staff trained to reach out to Medicaid eligible clients.

Enabling: Title V MCH and State General funds are used to cover services to pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of health care coverage.

c. Plan for the Coming Year
July 2010 -- June 2011

Direct: DOH will continue to reach out to children and families to increase the number of children who are insured. This includes the efforts of Families FIRST and CMS staff who are actively involved in assisting families to complete the PE/MOSSA application.

Enabling: Title V MCH and state general funds will continue to be used to cover services for pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of coverage.

Infrastructure Building: DOH will work collaboratively with HSD to increase the number of eligible children enrolled in Medicaid. The Children's Cabinet continues to work with the Governor and the State Legislature to implement universal health care coverage for all New Mexicans, including

children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		24	24	21	24
Annual Indicator	24.2	25.6	26.3	25.7	25.7
Numerator	7579	5821	6493	7065	7065
Denominator	31271	22749	24691	27442	27442
Data Source				NM WIC Program	NM WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24	24	23	23	23

Notes - 2009
2009 data not yet available.

Notes - 2008
Source: New Mexico WIC program.
Numerator: Number of WIC children age 2-5 with a BMI at or above 85%
Denominator: Number of WIC children with a valid BMI.

The method of analysis, including how the denominator was derived for 2006 and 2007 was different from 2005. It is more accurate. 2006 and 2007 should not be compared to 2005.

Notes - 2007
Source: New Mexico WIC program.
Numerator: Number of WIC children age 2-5 with a BMI at or above 85%
Denominator: Number of WIC children with a valid BMI.

The method of analysis, including how the denominator was derived for 2006 and 2007 was different from 2005. It is more accurate. 2006 and 2007 should not be compared to 2005.

a. Last Year's Accomplishments
Enabling: Continue providing referrals to Child Medical Services (CMS), health care providers and therapists in the State of New Mexico who provide treatments to families with infants or children demonstrating feeding issues. Provide WIC clients individual counseling and nutritional support with eWIC cards (food benefit) at scheduled WIC appointments.

Population-Based: Continuing collaboration with the "The New Mexico Plan to Promote Healthier Weight" and other agencies by providing information to WIC clients and the communities they live

in

Infrastructure Building: Implement a Special Projects Grant that was awarded by USDA that will support the Food and Nutrition Service's initiative. The goal of this is to improve and strengthen the effectives of WIC nutrition services. NM WIC called the grant "Get Healthy Together: WIC staff and Clients Moving Toward Healthier Lifestyle". This project will replicate the staff wellness and self-efficacy training incorporated in previous Fit WIC projects. This project will implement obesity management skill training identified in and evaluated by Fit WIC projects.

Direct: Develop assessment tools to implement USDA Value Enhanced Nutrition Assessment (VENA) to connect nutrition assessment to effective/appropriate nutrition education that best meets each participant's needs. Provide in WIC Clinics statewide nutritional sessions and individual counseling on key messages using USDA materials, "FIT KIDS = HAPPY KIDS." The key messages are physical activity, decreasing TV and computer time, drinking more water and less sweetened drinks and eating as a family.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop assessment tools to implement USDA Value Enhanced Nutrition Assessment (VENA) to connect nutrition assessment to effective/appropriate nutrition education that best meets each participant's needs.	X			
2. Provide referrals to Child Medical Services, Families First, health care providers and therapists in the State of New Mexico who provide treatments to families with infants or children demonstrating feeding issues.		X		
3. Collaborate with “The New Mexico Plan to Promote Healthier Weight” and other agencies by providing information to WIC clients and their communities with the knowledge about attitudes and perceptions surrounding healthful eating and Physical.			X	
4. Motivational Interviewing training to all WIC staff				X
5. Implement the USDA “Get Healthier Together” Grant to support the Food and Nutrition Service’s initiative of Revitalizing Quality Nutrition Services in the WIC Program (RQNS).				X
6. Revise WIC food package to include a greater variety of healthy food choices that are culturally acceptable. The New Mexico WIC Program will implement the new food package by October 1, 2009.	X			
7.				
8.				
9.				
10.				

b. Current Activities

Direct: Provide individual nutrition assessment and counseling to all WIC participants at certification for the WIC Program. This includes weights and heights, nutrition assessments, and nutrition education plans for all participants. The WIC food package is being revised to include a greater variety of healthy food choices that are culturally acceptable. The WIC foods provided to families are specially designed to provide specific nutrients to help with the growth and development.

Enabling: Provide referrals to CMS and Families First providers and therapists who provide

treatment to families with infants/children demonstrating feeding issues.

Population-Based: Create public awareness of positive lifestyle changes and nutrition by through the NM WIC Internet site. Continue collaboration with the "The New Mexico Plan to Promote Healthier Weight" by providing information to WIC clients and the communities they live about healthful eating and physical activity.

Infrastructure Building: Continue with year three of implementing Special Projects Grant awarded by USDA that will support the Food and Nutrition Service's initiative of Revitalizing Quality Nutrition Services in the WIC Program (RQNS). The goal is to improve and strengthen the effectives of WIC nutrition services. NM WIC called the grant "Get Healthy Together: WIC staff and Clients Moving Toward Healthier Lifestyle".

c. Plan for the Coming Year

Direct: Develop and obtain 120 hours Nutrition Education Module that would be accessible for New Mexico WIC staff via intranet. Write policy and procedures for the training and process for training "Competent Professional Authority" (CPA) and Para-professional for the New Mexico WIC Program and submit for approval by the State Management Team.

Infrastructure Building: Continue to train staff on motivational interviewing to perform USDA Value Enhanced Nutrition Assessment (VENA) to connect nutrition assessment to effective/appropriate nutrition education that best meets each participant's needs.

Enabling: Continue providing referrals to Child Medical Services and Families First health care providers and therapists in the State of New Mexico who provide treatments to families with infants or children demonstrating feeding issues. Provide WIC clients individual counseling and nutritional support with food vouchers at scheduled WIC appointments.

Provide referrals to Child Medical Services, care providers and therapists in New Mexico who provide treatments to families with infants/children with feeding issues. Provide WIC clients counseling and nutritional support with food vouchers at scheduled WIC appointments

Population-Based: Create public awareness of positive lifestyle changes and nutrition by through the NM WIC Internet site. Continue collaboration with the "The New Mexico Plan to Promote Healthier Weight" by providing information to WIC clients and the communities they live about healthful eating and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		8.5	8.5	7.2	7.2
Annual Indicator	8.5	7.6	7.6	7.6	7.6
Numerator		2129	2129	2129	2129
Denominator		27936	27936	27936	27936
Data Source				NM PRAMS	NM PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7	7	7	7	7

Notes - 2009
2008 and 2009 Data are not yet available.

Notes - 2008
2008 Data are not yet available.

Notes - 2007
2007 data not yet available.

a. Last Year's Accomplishments
July 2008 -- June 2009

Direct: Families FIRST (FF) assessed the tobacco usage of pregnant women and parents of children 0-3 statewide. FF screened for usage, offered education related to risks for mom and baby, and education about the effects of second hand smoke. FF continued to develop and implement care plans to reduce or eliminate cigarette usage, and referred clients to smoking cessation programs where available. The registered nurse and licensed social worker case managers also provided follow-up services to monitor the progress of their clients monthly for identified problems. Pregnant women's risks were re-assessed every 3 months.

The Lifelong Happiness modules were implemented by Women, Infants and Children (WIC). Training modules for this project included materials and activities to educate women regarding the avoidance of tobacco during pregnancy. The project used materials that were specific to teen clients.

NM PRAMS surveys were sent and evaluated. These surveys assessed, among other activities, cigarette usage during the last three months of pregnancy. 2000 data showed that lower income women were more likely to smoke before or during pregnancy than others. Native American or Hispanic mothers were far less likely than non-Hispanic White mothers to smoke at any time. 20-24 year-old mothers were more likely to smoke than those over 25 years of age.

WIC, Family Planning and Prenatal Care screened for tobacco usage. WIC recipients received education related to the effects of smoking on the fetus. Moms were referred to smoking cessation programs where available.

Enabling services: The Department of Health's Tobacco Use Prevention and Control Program operates a 1-800-QUIT NOW telephone line which provides free counseling and free nicotine replacement patches, gum and lozenges. More than 2000 people, 8 of whom were pregnant women, called the help line during this time.

The Dee Johnson Clean Indoor Air Act began June 15, 2007. This act eliminates smoking in stores, offices, restaurants, bars and indoor public places.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Families F.I.R.S.T. will continue to provide case management for pregnant women including screening, assessment, education, care planning, referrals to smoking cessation programs and follow-up for tobacco use.	X			
2. WIC will continue to utilize their standard client history that includes assessment for tobacco use. They will provide motivational interviewing and refer as needed.	X			
3. Family Planning and Prenatal Care programs will continue to assess for tobacco usage and refer as appropriate.	X			
4. PRAMS will continue to survey for tobacco usage and report on the numbers of women who smoke in the last three months of pregnancy.	X			
5. TUPAC will continue to offer nicotine replacement services.		X		
6. The Dee Johnson Clean Indoor Air Act will eliminate smoking in stores, offices, restaurants, bars and indoor public places.		X		
7.				
8.				
9.				
10.				

b. Current Activities
7/2009 -- 6/2010

Direct: The Families FIRST Program(FF) offers statewide perinatal case management to pregnant women. Women are assessed for tobacco use and second hand smoke exposure. Second hand smoke was the most reported risk factor for FF pregnant clients in 2009. Case Managers(CM) educate women about the harmful effects to themselves and their babies. CMs develop plans of care, provide follow-up and monitor clients' progress. Pre-term labor and compromised respiratory ailments are discussed. Referrals are made for smoking cessation classes. Services are now being documented in an electronic database and reports will be generated showing the number of cases screened and the numbers of pregnant women in the FF program who are reporting the use of tobacco and or exposure to second hand smoke.

Family Planning assesses women for violence, alcohol, substance and tobacco use. Pregnant, Medicaid eligible women are referred to FF and non-Medicaid eligible women are referred to prenatal care programs. Prenatal Care programs assess for tobacco use.

Family Planning offers Lifelong Happiness, a preconception health education project including materials, in English & Spanish, & activities to educate women regarding the avoidance of tobacco during pregnancy.

Enabling: The DOH's Tobacco Use Prevention and Control Program (TUPAC) maintains a website and reports that nicotine replacement doubles quit rates. This could reduce the State's future health care costs by $395.5 million

c. Plan for the Coming Year
July 2010 -- June 2011

Direct: Families FIRST, WIC, Family Planning, and Prenatal Care will continue to offer the assessment, education and referral services for smoking that they are presently providing to pregnant women. WIC nutritionists will offer the Lifelong Happiness: Preconception Health Education Project modules related to smoking, and other harmful behaviors, using motivational interviewing to encourage pregnant women to reduce and quit smoking during pregnancy. PRAMS will continue to survey women related to tobacco usage. Results produced from the FF

database analysis will be evaluated to direct future educational efforts to reduce the incidence of tobacco use.

Enabling: TUPAC will continue to offer free nicotine replacement (in patches, lozenges and gum) to New Mexican tobacco users who enroll in the "Quit for Life" program. The Dee Johnson Act will continue to eliminate smoking in public places. New Mexico is imposing an additional 75 cents per pack tax on cigarettes.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.5	13.5	13.5	21	16
Annual Indicator	16.5	22.8	18.5	18.5	18.5
Numerator	25	35	31	31	31
Denominator	151865	153429	167360	167360	167360
Data Source				NMVRHS analysis by MCH Epi	NMVRHS analysis by MCH Epi
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16	16	16	16	16

Notes - 2009
2008 and 2009 data not yet available.

Notes - 2008
2008 data not yet available.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2007
Future performance objectives have been raised to a more attainable level.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older

age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

a. Last Year's Accomplishments
July 2007 -- June 2008

Direct Health Care: Family Health in partnership with OSAH continued efforts to reduce youth suicide by implementing evidenced based tools such as the Signs of Suicide (SOS) curriculum, community coalition building, screening/early identification, referral and treatment. Targeted training was provided to schools with school-based health centers on suicide crisis planning and response and a peer-to-peer program entitled "Natural Helpers" was implemented with eight schools. OSAH also supported and coordinated statewide crisis line activities. Two additional crisis lines were funded and linked to the National Talk Line (1-800-272-TALK). OSAH completed its final year of a SAMHSA funded demonstration project that incorporated eight Universal, Selective, and Indicated strategies. The initiative served four diverse rural communities and implemented screening, assessment and treatment programs for high school youth.

Enabling Services: Family Health and OSAH are partnered with inter-departmental workgroups, Value Options, and the Behavioral Health Collaborative to evaluate and recommend strategies to improve statewide behavioral health infrastructures for youth at-risk for depression and suicide through the Success in Schools committee. The redesign of New Mexico's behavioral health system created opportunities to increase interagency collaboration, assess infrastructure issues to improve the delivery of behavioral health services, and increase community collaboration focused on reducing youth suicide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Use of NM Child Fatality review findings about suicide for policy and program planning.				X
2. Suicide prevention training in schools			X	
3. Gatekeeper training in communities			X	
4. Public and professional training sessions, educational and informational sessions are ongoing	X			
5. NM Crisis line implemented statewide and toll free	X			
6. Signs of Suicide peer based gatekeeper training in schools	X			
7. Identify youth at risk and assure access to mental health services		X		
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: Promote suicide prevention/intervention through schools & school-based health centers (SBHC). Technical assistance/training provided to school staff on linking school safety planning to suicide/crisis/grief planning & response. OSAH to partner with the PED to coordinate training/provide resources to increase skills, knowledge & awareness of school personnel; will continue work with the university depts. of Psychiatry & Pediatrics to expand telehealth for SBHCs, & facilitate peer-to-peer youth programs to promote awareness & resiliency.

Enabling: Partnership with inter-departmental workgroups, Optum Health & the Behavioral Health Collaborative to evaluate and recommend strategies to improve behavioral health infrastructure for youth at risk for depression and suicide.

Population: Statewide educational efforts about youth depression. Trainings on signs of suicide, crisis planning & response & reducing mental health stigma. Include behavioral health track at Head-to-Toe Conference. Partner with NM Suicide Prevention Coalition & NM Suicide Intervention Project to provide community-based awareness & crisis response.

Infrastructure: Participate in NM Child Fatality Review to monitor trends & inform policy-makers, programmers & community partners. The OSAH continues to use a health care quality initiative in SBHCs to improve infrastructure, quality of integration between primary & behavioral health care & enhancement of SBHC administrative functions.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: Family Health in partnership with OSAH will continue to promote suicide prevention and intervention through schools and school-based health centers. Technical assistance and training will be provided to school staff on linking school safety planning to suicide/crisis/grief planning and response. OSAH, in partnership with Public Education Department, will coordinate training and resources necessary to increase suicide reduction skills, knowledge and awareness of school personnel. OSAH will expand the availability of telehealth services that link school-based health centers statewide to behavioral health specialists, including psychiatrists. OSAH will continue to support the SAMHSA funded demonstration project that incorporated eight Universal, Selective, and Indicated strategies in the original four diverse rural communities that implemented screening, assessment and treatment programs for high school youth. Natural Helpers Program will be expanded into two additional schools.

Enabling: Family Health and OSAH will partner with inter-departmental workgroups, Optum Health and the Behavioral Health Collaborative to evaluate and recommend strategies to improve statewide behavioral health infrastructure for youth at risk for depression and suicide. OSAH will fund three crisis lines (UNM Agora, NMSU Call Line, and Santa Fe Crisis Line) that are linked to the National Talk Line (1-800-272-TALK). OSAH will partner with UNM Pediatrics to improve provider practices in early identification and screening for youth with depression.

Population: Family Health with OSAH plans educational efforts engaging the public and professionals about youth depression. Trainings will focus on the signs of suicide, crisis planning and response among adolescent populations and reducing mental health stigma. OSAH will include a behavioral health focused track at the annual Head-to-Toe Conference, including workshops and presentations on Youth Suicide Prevention. OSAH will partner with youth suicide prevention organizations and agencies to provide community-based activities such as gatekeeper and anti-stigma awareness and training, and crisis response planning.

Infrastructure: OSAH will participate in regular DOH cross-agency workgroup meetings to address data collection and reporting on prevention activities for all age groups. The workgroup will continue to utilize data from the NM Child Fatality Review to monitor trends and inform policy-makers, organizations and communities, program planning and policy-making. OSAH will use a health care quality initiative in SBHCs to improve infrastructure, including increasing quality of integration between primary and behavioral health care staff; enhancement of school-based health center administrative functions needed for sustainability (ie, successful Medicaid billing and reimbursement for services.)

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	70	70
Annual Indicator	71.3	67.6	67.6	67.6	67.6
Numerator	216	286	286	286	286
Denominator	303	423	423	423	423
Data Source				NMVRHS	NMVRHS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	70	70	70

Notes - 2009
2008 and 2009 NMVRHS data not yet available.

Notes - 2008
2008 NMVRHS data not yet available.

Notes - 2007
2007 and 2008 delivery by facility data are not yet available.

a. Last Year's Accomplishments
July 2008 -- June 2009

The total number of low birthweight infants increased from 365 in 2005 to 409 in 2007. However, the percentage of infants meeting this criteria who were born in facilities equipped to care for high-risk neonates also increased from 76% to 78%. Continued outreach and education influenced providers and facilities to implement strategies to transfer care of pregnant women and at risk babies to these facilities. Collaboration with the University of New Mexico (UNM) Maternal Fetal Medicine (MFM) and the Maternal Health Program resulted in this overall awareness and increase.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contract with providers of high risk and low risk prenatal care to women with no other means of access.				X
2. Partner with stakeholders to upgrade staff, capacity and systems of transport.				X
3. Analyze linked birth-death data to identify gaps or disparities.				X
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Infrastructure Building:
In 2007, 409 very low birthweight infants were born in New Mexico representing 1.3% of all live births (NM Vital records). Of these 409 births, 78% took place in a facility for high-risk deliveries of neonates.

Maternal Health collaborates with the UNM MFM and Presbyterian Medical Group perinatologists to provide care to high risk, medically indigent women. Through the High Risk Prenatal Care Fund (HRF) these services are provided to patients free of charge. Services are provided by at the UNM Health Sciences Center in Albuquerque, UNM outreach clinics and Presbyterian hospitals and clinics throughout the State. The clinics are staffed by perinatologists, nurses and social workers, and provide high level evaluation and consultation. UNM maintains the Physician Access Line for Service (PALS), providing statewide access to a perinatologist for telephone consultations and to arrange transport for patients requiring intensive management at the university. Additionally, UNM Telemedicine offers the High Risk Pregnancy direct patient evaluation, real-time fetal ultrasound analysis and counseling.

This network of care is designed to prevent low birth weight births through specialized care to the mother. These high risk providers are most likely to anticipate and recognize conditions where delivery at a tertiary care center is desirable and make appropriate transfers of care to them.

c. Plan for the Coming Year
July 2010 -- June 2011

Infrastructure Building: Continue to support UNM and Presbyterian perinatology clinics and outreach programs. Continue to maximize effectiveness of the HRF, which consists of agreements with a network of high-risk prenatal care providers which obligates them to provide services for high-risk medically indigent women at no cost to the client.

Continue to improve data on gaps and disparities in transport of appropriate women to tertiary care facilities for delivery and partner with UNM perinatologists to develop strategies for improving rates of very low birth weight infants born in tertiary care centers.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	71	71	71	74	75
Annual Indicator	70.3	71.3	74.8	74.8	74.8
Numerator	19590	21339	22606	22606	22606
Denominator	27862	29918	30204	30204	30204
Data Source				NMVRHS	NMVRHS

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	76	76	76	76	76

Notes - 2009
2008 and 2009 data not yet available

Notes - 2008
2008 data not yet available.

a. Last Year's Accomplishments
July 2008 -- June 2009

Infrastructure Building: Maternal Health administers multiple provider agreement contracts for the delivery of routine prenatal care. Provider agreements were in place for First Step Center and Memorial Hospital in Las Cruces; First Choice Community Health Clinics in Albuquerque, Los Lunas and Belen; First Nations Community Health sources in Albuquerque and Soccoro; UNMs Maternal & Family Planning Clinics throughout Albuquerque; and UNM Hospital. All of these clinics and hospitals agree to see an unlimited number of pregnant women for routine prenatal care and screening, birthing services and postpartum care. Additionally, the Program negotiated with SED laboratory and 3 ultrasound providers for reduced cost services for these clinics. These contracts totaled just over $857,000 and provided the vast majority of prenatal care for uninsured women in New Mexico. Funding for this care comes from both the Federal Maternal and Child Health Services Title V Block Grant Program with matching funds from the General Fund.

Maternal Health Program provided logistical and program support for the delivery of prenatal care in 10 Public Health offices. These PHOs, located in Regions 4 and 5; Lea, Eddy, Lincoln, Sierra, Socorro, Luna and Torrance Counties, serve at least 700 low-risk women per year who would not otherwise have access to prenatal care. 90% of these women are uninsured, poor, and not eligible for Medicaid coverage for prenatal care. 10% of these women are Medicaid-covered but lack transportation to other prenatal care providers. Services the Program provided include evidence based practice protocols, documentation compliance review, training workshops and continuing education opportunities, text and web based resources, client education materials, access to routine laboratory testing for patients through the Program's contracted with SED Medical Lab, pharmaceuticals and medical supplies through the Public Health Division Pharmacy, and technical support.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide case management to Medicaid-enrolled pregnant women, including assistance with accessing prenatal care.				X
2. License and regulate certified nurse-midwives and licensed direct-entry midwives, who provide prenatal care.				X
3. Provide support for prenatal care in local health offices to women who have no other source of care.				X

4. Administer contractual agreements with clinics to provide prenatal care for medically indigent women.				X
5. Assess access disparities, gaps and barriers to prenatal care services.				X
6. Use NM PRAMS data, Vital Records data and other information to identify key factors, gaps and disparities associated with late entry and low level of care.				X
7. Partner with state and community entities to develop and implement strategies for improving access to prenatal care.				X
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

The Birthing Workforce Retention Fund (BWRF) is administered by Maternal Health. This fund provides malpractice insurance premium assistance for MDs and CNMs whose insurance premium costs jeopardize their ability to continue their practices in NM. The average cost of malpractice insurance for providers of birthing services in NM was $36,365 for 2009. The Program advertises the fund, screens applicants and processes awards. In FY09 $40,000 was awarded to 8 providers to assist these providers in maintaining viable practices in underserved areas of NM thereby assuring access to prenatal care
Maternal Health Program licenses and regulates CNMs & LMs who provide prenatal, delivery and postpartum care for approximately 33% of the birthing mothers in NM. For LMs, Maternal Health developed a course on optimizing the experiences of women, newborns & their families whose care is transferred from home to hospital. For CNMs, Maternal Health revised and enacted the new CNM rule reducing barriers to practice and updating standards of care for well woman, prenatal and delivery services.

Maternal Health continually updates phone surveys to assess services and gaps in prenatal and delivery care in each county. MH invites and facilitates ongoing discussions with stakeholders to identify barriers to care, culturally relevant care initiatives, methods to increase access to prenatal care, and incentives to recruit and retain pregnancy care providers.

c. Plan for the Coming Year
July 2010 -- June 2011

Continuation of all of the above mentioned programs is essential to the continued access for women to adequate prenatal care. Decreased funding on both the state and federal level will make this continuation difficult but not impossible. Parternering with the University of New Mexico, private practitioners, the New Mexico Midwives Association, the NM chapter of the American College of Nurse Midwives, and institutions throughout the state to form agreements to provide the timely and adequate care to women will be the main focus of the Maternal Health Program.

D. State Performance Measures

State Performance Measure 1: *The number of New Mexico counties and tribal entities implementing positive youth development strategies defined by 6 key criteria*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		6	6	6	6
Annual Indicator		6	6	6	6
Numerator		6	6	6	6
Denominator	6	6	6	6	6
Data Source				AHP	AHP
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	6	6	6	

Notes - 2009
An accurate number is not currently available.

Notes - 2008
An accurate number is not currently available.

Notes - 2007
An accurate number is not currently available.

a. Last Year's Accomplishments
July 2008-June 2009

The following activities were accomplished:
Statewide Youth Leadership Forums/Groups/Peer-to-Peer Help Programs

1. 13th Annual Head to Toe Conference- Youth-Adult Partnership Track offered adolescent health focused workshops that were youth and adult led including teen pregnancy (April 2009, ~50 Youth)

2. Organizing Youth Engagement (OYE) For Change - Create, Harness, Advocate, Network, Gather, Energize (June 2009, ~110 Youth)

3. Indigenous Soccer Cup- Soccer Tournament, Health & Leadership Workshops/Events, Promotes Native American Culture (July 2009, ~250 Native Youth)

4. Legislature Training- Crafting a Strong Message, Talking Points, Addressing Legislatures, Advocacy (March 2009, ~80 Youth)

5. Native HOPE (Helping Our People Endure 2 Day Training)- Laguna Pueblo Middle School and Crownpoint High School (May, 2009, ~150 Pueblo Youth). Both of these were pilot sites to develop Youth Councils who move the strategic action plans forward utilizing youth voice.

6. Natural Helpers Program- Implemented in Pojoaque, Carlsbad, Gadsden, Gallup, Capital and Santa Fe

OSAH developed the first Positive Child and Youth Development Proclamation in collaboration with NM Forum for Youth in Community, NM Children's Cabinet, NM Alliance for School Based Health Care, NM Human Service Department, NM Children, Youth and Family Department. March 10th was also School Health and Positive Youth Development Day at the NM Legislature.

OSAH is collaborating with the NM Forum for Youth in Community on creating and implementing the Youth Health Link website. This website will be a one stop-shop portal for youth health information, linking numerous websites and resources for youth and youth partners to access.

Youth voice was incorporated into the design of www.YouthHealthLink.org

OSAH collaborated with Southwest Youth Services (SYS) to provide AmeriCore VISTA's in Native communities to assist in promoting the positive youth development approach. This effort has helped SYS to expand its programming to obtain a 3-year AmeriCorps contract to develop a 40 member project in NM called the Native Youth Wellness Corps Project (NYWC). Fourteen new AmeriCorps VISTA members are currently serving in five Native communities and programs in NM.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Youth Leadership Forum				X
2. Youth Health Link communication tool develoment			X	
3. Youth Advisory Group Project			X	
4. Support for positive youth development programs				X
5. School Health Day at the NM Legislature				X
6. 14th Annual Head to Toe Conference				X
7.				
8.				
9.				
10.				

b. Current Activities
July 2009-June 2010
The current activities include:

1. Planning for the following Statewide Youth Leadership Forum -- 14th Annual Head to Toe Conference- Youth Track, Organizing Youth Engagement for Change and Indigenous Soccer Cup. Roswell is also having a Suicide Prevention Conference for youth and adults. Young people are on the planning committee.

2. Maintaining and Updating Youth Health Link Website and disseminating Youth Health Link Newsletter(s) and Update(s).

3. Developed draft of Native HOPE toolkit

4. Implement an Adolescent Health Survey which will provide a snapshot of adolescent health activity in NM and gathered resources for the Youth Health Link Website.

5. Natural Helpers Program- Implemented in Pojoaque, Carlsbad, Gadsden, Gallup, Jemez, Reserve, Belen, Kirtland, Capital and Santa Fe

6. Collaborated with key adolescent health stakeholders to developed 2nd Positive Child and Youth Development Proclamation and plan the Children's Cabinet Days at the Legislature.

c. Plan for the Coming Year
July 2010-June 2011

This year's activities include the following:

1. Research and develop a Positive Youth Development Training material that can be adapted to fit the needs of the target audience and illustrates activity at various levels of the socio-ecological model. This training material will be utilized in a training of trainers' workshop.

2. Complete Native HOPE toolkit- The purpose of the toolkit is to provide resources that will simplify the process for communities and eliminate duplication of efforts. Documents will be adaptable to the communities needs. The next step will be to pilot the toolkit with a couple of communities interested in implementing Native HOPE.

3. The 15th Annual Head to Toe Conference will continue to promote the positive youth development approach.

4. Continue to update and maintain the Youth Health Link Website and disseminating Youth Health Link Newsletter(s) and Update(s).

5. Recruit and develop work groups for the seven capacity areas of the Adolescent Health Strategic Plan which will include the steering committee.

6. Present at various events bringing awareness of the positive youth development approach.

7. Continue to provide technical assistance to support on positive youth development programs and activities, as well as promote collaboration among groups or organization doing similar work.

8. Collaborate with planning and implementing the 3rd Annual Indigenous Soccer Cup gathering.

9. If economic situation permits, continue to support Positive Youth Development Programs such as: Native HOPE (Helping Our People Endure), Natural Helpers, and Teen Outreach Program (TOPs).

State Performance Measure 2: *Percent of first newborns/moms receiving support services/parenting through community home visiting/support programs*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.7	10	10	22	22
Annual Indicator	21.0	20.1	16.6	16.6	16.6
Numerator	3543	2096	1812	1812	1812
Denominator	16879	10417	10893	10893	10893
Data Source				NM PRAMS	NM PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	22	22	22	22	

Notes - 2009
2008 and 2009 PRAMS data not yet available.

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 PRAMS data not yet available.

a. Last Year's Accomplishments
July 2008 - June 2009

Direct: Continued to provide home visiting and case management services to pregnant women and children 0-3years through the statewide Families FIRST program. Families FIRST clients received case management services which usually included at least one home visit during the planned dates of service. Families in Las Cruces received personal visits through the Parents As Teachers program aimed at providing information, support and encouragement to parents of children from birth to three years.

Enabling: In 2009 Title V supported a home visiting contract to provide parenting education and support services to 25 families of newborns in the city of Las Cruces.

Infrastructure Building: Partnered with state and community agencies to support other home visiting programs such as the First Born Program, and the Children, Youth, and Families Department (CYFD) home visiting programs which have expanded their services statewide. The Families FIRST program participated in a state work group which evaluated and discussed the state funded home visiting programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home visiting through Families First program	X			
2. Collaboration with other state agencies to evaluate state home visiting programs and to secure continued funding for home visiting.		X		
3. Continued partnership with community agencies to implement the Infant Mental Health Strategic Plan of New Mexico.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2009 - June 2010
Direct: Providing home visiting through the Families FIRST program (statewide), and the Parents As Teachers program in Las Cruces.

Enabling: Several staff members are participating as members of a work group comprised of multiple state and private agencies that are meeting to discuss the recommendations in the report published last year titled "Building a System of Home Visiting in New Mexico." There has been a review of evidence based, and non-evidenced based programs, keeping in mind the need to have programs that are culturally sensitive to the needs of the citizens of New Mexico.
We are using Child Health funds to maintain the Las Cruces Home Visiting contract. The Child Health Educator is providing staff development as needed to assure knowledge, skills, and abilities to provide Title V leadership in public health assessment, assurance, and policy development.

Infrastructure Building: Promoting best practice in primary prevention home visiting and

integrating identified home visiting priorities into the work of the Early Childhood Comprehensive Systems and Project LAUNCH grants.

c. Plan for the Coming Year
July 2010 - June 2011

Direct: Provide home visiting through the Families FIRST program (statewide).

Enabling: Utilize the Child Health Educator to continue to provide staff development as needed to assure knowledge, skills, and abilities are provided to Tile V leadership in public health assessment, assurance, and policy development. Continue to actively participate in the state work group to evaluation state home visiting programs, make recommendations for the funding of future programs and the expansion of existing programs, and develop a definition of home visiting for New Mexico.

Infrastructure Building: Continue to partner with state and community based agencies to achieve the Infant Mental Health Strategic Plan Training Goal. Promote best practice in primary prevention home visiting. Integrate identified home visiting priorities into the work of the Early Childhood Comprehensive Systems and Project LAUNCH grants. Promote home visiting occurring through the Families FIRST program (statewide) and secure funding to expand the existing programs and establish future programs.

State Performance Measure 3: *Reduce unintended pregnancy in New Mexico to less than 30% of births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	42.5	42.5	42	42	41
Annual Indicator	43.3	45.8	43.7	43.7	43.7
Numerator	19204	12763	12453	12453	12453
Denominator	44310	27870	28477	28477	28477
Data Source				NM PRAMS	NM PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	41	41	41	41	

Notes - 2009
2008 and 2009 PRAMS data is not yet available.

Notes - 2008
2008 PRAMS data is not yet available.

Notes - 2007
The 2007 PRAMS response rate was less than 70%, therefore the data should be interpreted with caution.

a. Last Year's Accomplishments
July 2008 -- June 2009

Direct Health Care: FPP received additional funds from Title X for the hard-to-reach population in two NM counties in need of publicly-funded family planning clinical services.

In calendar year 2009, the clinics served 45,693 unduplicated clients (37,683 females and 8,010 males). This represents a 12.2% increase from 2008 (5,553 clients). The increase was seen in both female (1,500/4% increase) and male (4,053/50.6% increase) clients.

The FPP collaborated with the Maternal Child Health Program to revise the Contraception, Preparing for Post-partum Section of the 2009 NM DOH Prenatal Protocol. Clients seen in local public health offices (PHOs) for prenatal care during their third trimester were to be counseled on their postpartum contraceptive options and helped to develop a practical plan to prevent unwanted pregnancy. The nurse may dispense condoms for postpartum use as needed and may dispense up to three cycles of Progestin-only pills during the third trimester to a client who chooses them for postpartum use.

Enabling Services: The PHOs provided outreach through local schools (2 new sites), community colleges, alternative high schools, family-related organizations and youth groups.

NM DOH recruited a full time Spanish translator on staff. She was available for Spanish translation of written materials as well as assessing reading levels.

Population Based Services: The PHOs provided education and outreach for clients aged 15-17 at schools, detention centers, and community centers on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually-transmitted infections.

In 2008, in order to gauge their awareness and understanding of the Emergency Contraception Pill (ECP) Plan B, the FPP, in collaboration with NM Medicaid Family Planning Waiver Program, funded Cooney, Watson & Associates, Inc. to conduct a survey of 21 Hispanic females between the ages of 15 and 35 who were WIC clients. Roughly two-thirds of the focus group participants were Spanish-speaking (i.e., Spanish was their first language). The purpose of the survey and subsequent focus groups was to 1) assess awareness of Plan B among this group; 2) assess the group's understanding of Plan B -- i.e. what it is, how it works, who is eligible to get it and where is it available; and 3) identify specific messages and visual triggers that participants responded to for use in future development of public awareness materials designed to target this particular group.

The survey findings were used to develop media messages using the two forms of media preferred by the participants, radio spots and the ECP Pharmacist Card; both are available in English and Spanish. These media materials were tested with subsequent focus groups and edited in 2009.

Infrastructure Building: FPP continued to monitor quality through needs assessment, client surveys, client-centered care and the electronic medical record system.

The annual client satisfaction survey was distributed to clients seen at local PHOs. In 2009, there were 1,750 PHO clients who took the survey (1,607 females and 72 males). On the survey date, 538 female clients listed they had a pregnancy test done, 149 of which had a positive pregnancy test. Of the 149 positive pregnancy tests, 143 clients (96%) responded to the pregnancy intendedness question; 53 (36%) wanted to be pregnant now or sooner, 70 (47%) wanted to be pregnant later and 20 (13%) did not want to be pregnant now or anytime in the future. From this limited survey of PHO clients, among women who received a pregnancy test on the survey date and had a positive result, 60% reported unintended pregnancy. These women, however, may or may not receive contraceptive services prior to this survey.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase services to hard-to-reach populations	X			
2. Increase the number of service sites where possible and expand hours. Family Planning services will be provided during flex hours.	X			
3. Provide outreach clinical services through partnering with community-based organizations and other public health providers that work with vulnerable or at-risk populations.		X		
4. Provide education outreach through local PHOs at community sites, civic organizations, and faith based sites. Teens will receive family planning education.			X	
5. Ensure quality assurances through training, client surveys and client centered care.				X
6. Develop community networks- Family Planning will network with local physicians, health councils, MCH councils, faith-based organizations, school-related contacts, and detention centers.				X
7.				
8.				
9.				
10.				

b. Current Activities
July 2009 -- June 2010

Direct Health Care: FPP continues its efforts to increase the number of women and men served at NM DOH FPP family planning clinics statewide. FPP continues expanded services in 23 Family Planning funded sites that offer expanded clinic hours.

Enabling Services: PHOs provide clinical outreach through local and alternative schools, community colleges, family-related organizations and youth groups, jails, and detention facilities.

The NM DOH Office of Health Equity in the Division of Policy and Performance is preparing standard signage in Spanish to help clinics inform clients of the availability of translation services, and currently providing live as well as telephone translation services to DOH programs. In April 2010, the 2010 FPP Protocol will add the U.S. Census "ISpeakCards2004" and emphasize in the protocol the clinic's legal responsibility to provide fundamental language assistance to clients with limited English proficiency.

Population Based Services: FPP continues to provide outreach and education through PHOs.

The ECP media campaign was launched in 2010.

Infrastructure Building: FPP monitors quality through needs assessment, client surveys, client-centered care electronic medical records.

On April 9, 2010, the NM DOH FPP held Title X Fee Collection training via Webinar. Participants included PHO clinic staff. There will be 4 additional Webinar trainings on preferred family planning topics (determined by the 2009 training needs assessment).

c. Plan for the Coming Year
July 2010 -- June 2011

Direct Health Care: In 2008, FPP received additional funds from Title X for 3 years to serve hard-to-reach population in two NM counties in need of publicly-funded family planning clinical services. One of these two Title X Expansion Fund sites is the Alamosa PHO in the South Valley area of Albuquerque. One of the Alamosa PHO clinical staff plans to attend FPP sponsored training on providing health education to males.

The new Title X priority is on reproductive life planning. The philosophy of the integrative approach incorporating family planning services as a part of client's reproductive life plan is as follows:

1. Routine health promotion activities for all women of reproductive age should begin with screening women for their intentions to become or not become pregnant in the short- and long-term and they risk of conceiving (whether intended or not).

2. Providers should encourage patients (women, men, and couples) to consider a productivity life plan and educate clients about how their reproductive life plan impacts contraceptive and medical decision-making.

3. Every woman of reproductive age should receive information and counseling about all forms of contraception and the use of emergency contraception that is consistent with their reproductive life plan and risk of pregnancy.

Enabling Services: The local PHOs will continue to provide outreach clinical services through partnering with community-based organizations and other public health providers that work with vulnerable or at-risk populations.

Population Based Services: The PHOs will continue to provide outreach and education at community & faith based sites and civic organizations. The outreach efforts will target hard-to-reach populations such as incarcerated, homeless, adolescents and males.

Infrastructure Building: The FPP will continue to monitor quality through needs assessment, client surveys, client-centered care, clinic efficiency assessment and electronic medical record system.

The FPP will continue to develop community networks and provide support to coalitions already in place for youth development programs and interventions.

State Performance Measure 4: *Reduce the number of children witnessing violence (exposed to domestic or sexual violence) as expressed by percent of children present at a domestic violence scene.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	13	13	20	17
Annual	18.9	22.4	18.7	18.7	18.7

Indicator					
Numerator	4600	4766	3184	3184	3184
Denominator	24362	21251	17016	17016	17016
Data Source				www.health.state.nm.us/pdf/DVinNewMexico2007	www.health.state.nm.u
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17	15	15	15	

Notes - 2009
2008 and 2009 data not yet available.

Notes - 2008
2008 data not yet available.

Notes - 2007
Denominator: the Number of Law Enforcement Domestic Violence Reports Documenting Status of Children Present.

Numerator: Number of Children Present at the Scene of Domestic Violence Incidents.

Source:Incidence and Nature of Domestic Violence in New mexico VIII: An Analysis of 2007 Data From the New Mexico Interpersonal Violence Data Central Retgistry.

http://www.health.state.nm.us/pdf/DVinNewMexico2007.pdf

Future performance objectives have been raised to a more attainable level.

a. Last Year's Accomplishments
July 2008-June 2009

Direct Health Care: The ten Sexual Assault Nurse Examiner (SANE) programs around the state continue to respond to child sexual abuse using specially trained medical providers and statewide guidelines and medical forms for consistency, SANE programs served 256 children 12 years and younger. Last year, SANE recruited over 25 new specially trained nurses and provided four conferences, three of which were specific to documentation and treatment of child sexual abuse. The South Valley Male Involvement Project (SVMIP), in partnership with the Albuquerque Public Schools, hosted a conference for youth to discuss strategies to help end violence in their communities.

Enabling Services: The statewide Network Collaborative continued to convene and address issues related to violence against women and children. This fiscal year, specific attention was focused on teen dating incidence and prevention. The New Mexico Clearinghouse on Sexual Abuse and Assault Services (NMCSAAS) continued to review and distribute materials statewide. Support continued for the Las Cruces Home Visiting Program. Work continued with Para Los Niños.

Population Based Services: Additional outreach was provided to men and male youth to educate and enroll them as part of the solution in the struggle against domestic violence by working closely with the SVMIP.

Infrastructure Building: Activities and outreach of the statewide collaborative, The Network,

working to end domestic and sexual violence in NM were expanded. Work continued with the New Mexico Coalition Against Domestic Violence (NMCADV) to focus more on children witnessing violence programs. Safe Families Action Learning Lab (ALL) awarded NMDOH Maternal and Child Health and Office of Injury Prevention a two-year grant. The ALL project, a CDC-funded partnership effort between The Association of Maternal and Child Health Programs and Family Violence Prevention Fund (FVPF), began February 2007 and continued through January 2008. The goal of ALL was to integrate family violence assessment, intervention and prevention for minority women in perinatal disparities and safe motherhood programs. NM's ALL team worked to improve collaboration between the family violence and perinatal provider communities, to raise awareness of relationships between family violence and reproductive and perinatal health outcomes, to address perinatal providers' screening practices, and to raise awareness of clients at perinatal and reproductive clinics about family violence. A statewide providers meeting took place in Albuquerque to increase awareness of appropriate methods for universal screening for lifetime exposure to violence, increase knowledge of the link between lifetime exposure to violence and reproductive health outcomes, and increase awareness of available perinatal services for family violence. FVPF provided training, and the ALL team conducted a pre- and post-test survey to assess current screening practices, knowledge and attitudes toward screening, barriers to screening, and referral patterns.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State Early Childhood Comprehensive Systems (ECCS) grant is to assist States and territories in their efforts to build programs supporting families by offering parent education, family support, access to health insurance, and early childcare.				X
2. Provide primary prevention home visiting services to Las Cruces Public School families from prenatal stage to child's third birthday with 4 program components: Home Visits, Health Promotion/Developmental Screening, Resource Network, & Group Meetings.		X		
3. Para Los Niños clinic in Albuquerque provides outreach education and prevention programming to children, professionals and communities, and also provides diagnosis and investigation of cases of child sexual abuse and sexual assault of adolescents.	X			
4. Continue to expand the activities and outreach of the statewide coalition				X
5. Continue to expand SANE programs in the state.	X			
6. Partner with Office of Injury Prevention to increase awareness of universal screening for lifetime exposure to violence; increase knowledge of link between violence exposure & reproductive health outcomes, & of perinatal services for family violence.				X
7.				
8.				
9.				
10.				

b. Current Activities
2009-June 2010

Direct: SANE sponsors 2 annual trainings/genital skills labs for new nurses, promotes cross-training among co-responding agencies, and works on the consistency of statewide operations

through meetings/conferences, forms, and protocols. A training disc of 100+ injury photos to promote peer chart review and injury identification competencies was provided all SANE programs. Outreach and technical assistance was provided to new communities wanting to develop their own SANE program. A pilot effort of 3 mobile SANE kits was provided to existing SANE programs to improve their service delivery. SVMIP implements the Wise Guys curriculum to 5 schools with a chapter on dating violence. Work with Para Los Niños to provide medical evaluation + services for children + adolescents who have been sexually abused or assaulted.

Enabling: The NMCSAAS reviews and distributes materials relating to sexual assault/abuse. For the first time this year, the NMCADV received a grant to provide language, deaf, and hard of hearing interpreter services to victims of domestic and sexual violence.

Population: SANE Programs are active with prevention information during April, Sexual Assault Awareness Month.

Infrastructure: Work with The Network to end domestic & sexual violence in NM. Work with NMCADV to focus on children witnessing violence programs. ALL continued through Jan. The 10 SANE Programs are participating in an assessment of pediatric injury knowledge and documentation competencies.

c. Plan for the Coming Year
July 2010- June 2011

Direct Health Care: SANE will continue to offer standard activities including two annual SANE training and genital skills labs and convening of SANE Task Force meetings to ensure consistency in statewide operations and long-term planning of SANE development throughout the state. Due to the loss of a grant from Albuquerque Public Schools, SVMIP will not be conducting violence prevention activities.

Enabling Services: Continue to support home visiting services through the Las Cruces Public Schools.
Infrastructure Building: Site visit assessment of the ten SANE programs in their response, protocols, equipment, and practice of the child sexual abuse and adult sexual assault exam are on-going. ALL state teams will share capacity-building experiences and lessons learned with other states and territories (through direct mentoring, conference call presentation, or a scientific meeting presentation).

State Performance Measure 5: *Increase the proportion of women who report having all six criteria of the NM Healthy Birth Index*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12	12	12	12
Annual Indicator	11.4	11.8	11.1	11.1	11.1
Numerator	4631	3035	2922	2922	2922
Denominator	40466	25733	26327	26327	26327
Data Source				NM PRAMS	NM PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	12	12	12	12	

Notes - 2009
2008 and 2009 PRAMS data not yet available.

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 PRAMS data not yet available.

a. Last Year's Accomplishments
State Performance Measure 5 combines the following six factors of healthy pregnancy:

A. The pregnancy was intended
B. No binge or heavy drinking before or during pregnancy.
C. No smoking before or during pregnancy.
D. No physical abuse by husband or partner before pregnancy
E. Awareness and use of folic acid
F. Entered prenatal care first trimester

These factors combine to describe a context for healthy birth. At present, NM Title V approaches them partly collectively and partly separately. Information on activities connected with factors A, C, D and F are found within other state and national performance measures as follows:

A. See State Performance Measure 3, "Reduce unintended pregnancy in New Mexico to less than 30% of births".
C. See National Performance Measure 15, "Reduce the percentage of women who smoke in the last three months of pregnancy"
D. See related State Performance Measure 6, "Reduce the proportion of women who report being physically abused by husband or partner during pregnancy".
F. See National Performance Measure 18, "Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester".

Last year's accomplishments July 2008 -- June 2009

Population-Based: WIC standard client history included assessment for tobacco use and alcohol use, and for folic acid awareness. Family Planning, Families FIRST and Prenatal Care program protocols and forms called for standard client assessments to include intendedness of pregnancy, alcohol, tobacco and other substance use, and domestic violence. In each program, protocols require counseling and referrals to be given to those with positive responses. WIC also provides smoking cessation classes at their various offices. WIC used training modules for women developed by Children's Medical Services' Lifelong Happiness Project, consisting of materials and activities to educate women on health measures to decrease birth defects, including folic acid use and avoidance of alcohol and tobacco.

Infrastructure Building: Family Planning distributed V.A.S.T. Guidebook 2006: Screening for Violence, Alcohol Abuse, Substance Abuse, and tobacco Use in the Public Health Setting. Families FIRST switched from a paper documentation record to an electronic documentation record. This is greatly enhancing the program's ability to obtain and analyze outcome data. It is expected to more accurately capture screenings and counseling for alcohol, tobacco, substance use and domestic violence.

Enabling: Families FIRST annual statewide meeting, which is attended by all of the program's case managers, included a guest speaker presenting on educating clients about domestic violence, domestic violence screening, and referral to community resources.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC program offices provide smoking cessation classes	X			
2. Families FIRST provides case management for pregnant women of Medicaid, including assessment, referrals and follow-up for alcohol, and tobacco use.		X		
3. Pregnancy testing clinics in public health offices give prenatal vitamins with 400 mcg. folic acid to women who are pregnant/planning to become pregnant, with counseling on the importance and use of folic acid and avoidance teratogenic substances.	X	X		
4. WIC, Family Planning, Families FIRST and Prenatal Care programs' forms assess clients' substance use, folic acid awareness, pregnancy intendedness, and provide counseling and referral.			X	
5. Each of the 3 clinical contractors/19 clinics who have Provider Agreements with the Maternal Health Program are required to screen all patients for domestic violence, and substance use, and provide follow-up counseling/referrals as needed.			X	
6. Families FIRST and standard client assessments include domestic violence. In each program, protocols/guidelines direct providers to give counseling and referrals to those with positive responses.			X	
7. NM PRAMS surveys NM mothers on abuse by partner or husband before and during pregnancy.				X
8.				
9.				
10.				

b. Current Activities

Current activities July 2009-- June 2010

Population-Based: WIC providers continue to assess clients for tobacco use and alcohol use, and for folic acid awareness. Family Planning, Families FIRST and Prenatal Care providers continue to assess clients for intendedness of pregnancy, alcohol, tobacco and other substance use, and domestic violence. Counseling and referrals are given to those with positive responses. WIC provides smoking cessation classes at their various offices and educates women on health measures to decrease birth defects, including folic acid, avoidance of alcohol and tobacco and weight control.

Infrastructure Building: Data are collected through Families FIRST's electronic client records to be analyzed and used to improve the case management program's systems for helping women improve their health habits and work with their domestic violence situations and histories.

c. Plan for the Coming Year

Plan for coming year July 2010 -- June 2011

Population-Based: Current population-based activities will be continued in the next year.

Infrastructure Building: Families FIRST program will have a complete year's worth of data collected, will complete the analysis of the data, and will use the results to improve the case management program's systems for helping women improve their health habits and work with their domestic violence situations and histories.

State Performance Measure 6: *Reduce the proportion of women who report being physically abused by husband or partner during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		6.4	5	5	4
Annual Indicator	5.6	5.4	4.4	4.4	4.4
Numerator	2506	1494	1254	1254	1254
Denominator	44635	27683	28217	28217	28217
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	3	3	3	

Notes - 2009
2008 and 2009 PRAMS data not yet available.

Notes - 2008
Plesae note that the performance objective for 2008 should be "4."

Notes - 2007
2007 PRAMS data not yet available.

a. Last Year's Accomplishments
Last year's accomplishments July 2008 -- June 2009

Enabling: Families FIRST, WIC, Family Planning and Prenatal Care program standard client assessments continued to include domestic violence.

Population-Based:

Maternal Health Program continued its agreements with each of 30 clinics which provide prenatal care, requiring them to screen all patients for domestic violence and provide follow-up counseling and referrals as needed. This represents approximately 1,550 clients.

Infrastructure Building:

The timeline for the perinatal intimate partner violence mini grant began February 2007 and continued through January 2008. Training was conducted in August 2007 for the partners in the Family Health Bureau, Domestic Violence Statewide and/or Regional Agencies, and the University of New Mexico. Safe Families Action Learning Lab, one of the grantors, provided the presenter, and the NM team conducted a pre- and post-test survey to assess current knowledge, practices, and barriers. Posters from Family Violence Prevention Fund were distributed along with training materials for professionals at the training to post at their offices. A report was drafted of survey findings and shared with participants and other interested parties. The overall goal for the project is to build local providers' capacity to implement universal screening for family

violence and to better identify shared risk factors for reproductive health problems and violence. This grant ended with the Action Learning Lab and no longer exists.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families FIRST and Prenatal Care program standard client assessments will continue to include domestic violence, with counseling and referrals to those with positive responses.		X		
2. Maternal Health Program will continue to include requirements to screen all patients for domestic violence and provide follow-up counseling and referrals as needed in its agreements with clinics which provide prenatal care.			X	
3. NM PRAMS will continue to survey NM mothers on abuse by partner or husband before and during pregnancy.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current activities July 2009 -- June 2010

Enabling: Families FIRST, WIC, Family Planning and Prenatal Care program standard client assessments continue to include domestic violence.

Population-Based:

Maternal Health Program expanded agreements with 3 more clinics (total 33) which provide prenatal care, requiring them to screen all patients for domestic violence and provide follow-up counseling and referrals as needed. This represents approximately 1,550 clients. Maternal Health began a pilot program to administer the Edinburgh Postpartum Depression Screening to clients in 2 Public health offices in Santa Fe and San Miguel counties. Close links between domestic violence and maternal depression have been demonstrated. Screening and referral for maternal depression will result in better identification of women either at risk for domestic violence or already victimized by intimate partners. Referral resources are being concurrently developed along with this screening.

Infrastructure Building:

Maternal Health will continue parternering with WIC offices and public health offices as well as private practitioners to provide screening for both domestic violence and maternal depression to identify and refer women for necessary support services.

c. Plan for the Coming Year
Plan for coming year July 2010 -- June 2011

Enabling: Families FIRST, WIC, Family Planning and Prenatal Care program standard client

assessments will continue to include domestic violence. In each program, protocols/ guidelines call for counseling and referrals to be given to those with positive responses. NM PRAMS will continue to survey mothers on abuse by partner or husband before and during pregnancy.

Population Based:

Maternal Health Program agreements with each of 33 clinics which provide prenatal care required them to screen all patients for domestic violence and provide follow-up counseling and referrals as needed. The First Born home visiting program will begin to screen for domestic violence through a Project Launch grant. This program, which focuses on the physical, emotional and mental well-being of children 0-8 years, is now operating in three school districts within Santa Fe County.

Infrastructure Building: NM PRAMS will continue to survey mothers on abuse by partner or husband before and during pregnancy.

Family Planning Program distributed its V.A.S.T. Guidebook 2007: Screening for Violence, Alcohol Abuse, Substance Abuse, and tobacco Use in the Public Health Setting. It includes a Power Point presentation and a printed Guidebook, with background information on each topic, strategies to support behavior changes and for development and implementation of integrated systems for approaching V.A.S.T. issues with clients, and a bibliography. Parts of this handbook are still being used in programs, but it is currently in the process of being updated. Additionally, a version specific to WIC clients is being made in collaboration with the VAST committee and WIC.

State Performance Measure 8: *Increase the proportion of women who deliver a live infant who are reported to have been screened for syphilis during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective			89	89	90
Annual Indicator	89	75.6	75.6	75.6	75.6
Numerator		22042	22042	22042	22042
Denominator		29163	29163	29163	29163
Data Source				NMVRHS	NMVRHS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	

Notes - 2009
2008 and 2009 Birth files not yet available.

Notes - 2008
NMVRHS converted to a new electronic birth certificate in 2008 and current syphilis screening information will be available when that data becomes available.

Notes - 2007
There were 41 cases of primary, secondary and early latent syphilis reported for women aged 15-44 for 2006. The number of pregnant women screened during that year is not currently available.

http://www.nmhealth.org/std/pdf/PrimarySecondaryEarlyLatentSyphilisAgeSexCounty.pdf

In 2007, among women aged 10-54, there were a total of 39 cases of Syphilis.

15 cases of primary and secondary syphilis
24 cases of early-latent syphilis.

http://www.health.state.nm.us/std.html

a. Last Year's Accomplishments
Last year's accomplishments July 2008 -- June 2009

Population-Based:

Data from the STD Program, Infectious Disease Bureau indicated that in 2008 & 2009 there were 0 identified cases of congenital syphilis (CS) in NM. This represents a vast improvement over 2006 (7 cases) and 2007 (6 cases). Congenital syphilis is associated with fetal death, and in those who survive, vision and hearing loss, bone changes and developmental disabilities.

Effective prevention and detection of congenital syphilis depends on the identification of syphilis in pregnant women and, therefore, on the routine serologic screening of pregnant women during the first prenatal visit. In communities and populations in which the risk for congenital syphilis is high, serologic testing and a sexual history also should be obtained at 28 weeks' gestation and at delivery.

Data from the Bureau of Vital Records and Health Statistics birth file indicate that between 1990 and 2006, the percent of women delivering a live infant who were reported to have been screened for syphilis, decreased from 96% in 1990 to less than 89% in 2006. During this same time the incidence of congenital syphilis has been increasing. Both the proportion of pregnant women who were not screened increased (from 2.8% in 1990 to 6.5% in 2006) and the proportion of women for whom syphilis screening was not reported increased (from 1.7% to 5.2%).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. est women in DOH prenatal clinics on entry to prenatal care and at 28 weeks gestation. Provide counseling treatment and follow-up for positive-testing women.	X			
2. With provider partners, develop strategies to address the barriers identified.			X	
3. Assess the barriers to syphilis testing, follow up and treatment for pregnant women.				X
4. Inform providers of the requirements and recommendations for reducing CS; encourage and assist them to troubleshoot potential systems problems.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current activities July 2009 -- June 2010

Direct: Maternal Health Program continues educational efforts to inform OB/midwifery providers

of updated requirements and testing protocols on repeat syphilis screening at 28 weeks gestation for all pregnant women.

Infrastructure: A review of all known cases of congenital syphilis in New Mexico identifies the key problems to be lack of prenatal care, lack of screening for syphilis, lack of reporting, women discharged from hospitals before tests are reported and being lost to follow-up, & inadequate treatment for mother and newborn. Quarterly bulletins are sent to alert hospitals and staff in the most affected counties to the CDC's guidelines for testing/treatment of syphilis and state rules for testing for and reporting syphilis. Hospitals' systems for testing, reporting, treatment and follow-up are reviewed and discrepancies addressed.

Maternal Health Program also wrote letters to the current chair of the New Mexico ACOG chapter, the head of maternal/fetal medicine at University of New Mexico (UNM), and directors of the family practice and nurse-midwifery programs at UNM, notifying them of the above, requesting that they convey all of the information to their students, staff and colleagues, and that they troubleshoot potential systems problems and UNM hospital.

c. Plan for the Coming Year
Plan for coming year July 2010 -- June 2011

The Maternal Health Program will continue to reinforce the Prenatal Protocol requirement that all pregnant women be screened for syphilis at 28 weeks gestation. According to the NM STD Program all reported cases of syphilis in pregnancy are investigated.

Population-Based: The Department of Health Programs (Maternal Health, STD, Border Health) will work with providers throughout to develop strategies to facilitate the testing of all pregnant women.

Infrastructure Building: We will continue to assess and identify the key barriers to syphilis testing, reporting, treatment and follow-up on pregnant women. Based on this assessment, we will work with partners to develop the means to address each one. We continue to monitor the percent of women reported to have been tested on the birth file. STD program continues to provide follow up for all suspected women with syphilis and infants with congenital syphilis.

E. Health Status Indicators

Introduction
The key issues that affect the health of the MCH population are the high rate of poverty in the state and the disproportionate burden of coping with less social advantage, particularly among minority groups who make up the majority of this population. Gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or specialty care. Although the state has made progress in reducing the proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access to care for the working poor and immigrant families who come into the state -- many of whom pay taxes on their income. Programming throughout the Department of Health is designed with these issues in mind. Currently, due to staffing and resource shortages, much of the State's effort toward improving the status of the MCH population is focused on safety-net direct care services.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.5	8.9	8.7	8.7	8.7
Numerator	2493	2724	2722	2722	2722
Denominator	29256	30567	31174	31174	31174
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 NMVRHS data are not yet available.

Notes - 2008
2008 NMVRHS data are not yet available.

Notes - 2007
Source: NMVRHS, Analysis by MCH Epidemiology.

Narrative:
In New Mexico, the percent of low birthweight infants remained constant at 8.7% from 2007 to 2008. Although this percentage exceeds the national percentage of low birthweight deliveries (8.2%), New Mexico has been able to sustain viable programs designed to influence this indicator of maternal/child health.

The recent increase in births by elective and repeat cesarean section (scheduled cesarean section) contributes to the rate of late preterm births, which constitute a large proportion of low birth-weight babies, as there are no perfectly accurate predictors of fetal weight or gestational age against which to plan a delivery. Similarly, increases in elective and scheduled inductions contribute to the cesarean section rate, late preterm births and low birth-weight babies.

The Maternal Health program has made efforts to stabilize and/or decrease the number of low birthweight births by:

1. Recruiting and retaining a viable birthing services workforce in both rural and urban areas of the state through award and tax incentive initiatives designed to influence provider's ability and desire to practice obstetrics and midwifery in underserved locations

2. Maintaining funding for the High Risk Prenatal Fund which pays providers, clinics, hospitals, laboratories, ultrasonographers and social workers to provide prenatal care to high risk medically indigent pregnant women

3. Partnering with WIC and community agencies to enhance pre-conceptual counseling, inter-conceptual counseling, nutritional counseling, maternal depression screening and substance abuse screening

4. Disseminating evidence based data contraindicating elective inductions and cesarean sections based on consumer demand or provider convenience

5. Supporting and expanding care delivered by nurse-midwives and licensed midwives, whose services have been demonstrated to produce significantly fewer low-birth weight babies, due in part to their focus on prevention and nutrition, as well as reduction in use of unnecessary interventions

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.2	7.6	7.3	7.3	7.3
Numerator	2058	2245	2203	2203	2203
Denominator	28518	29714	30369	30369	30369
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 NMVRHS data are not yet available.

Notes - 2008
2008 NMVRHS data not yet available.

Notes - 2007
Source: NMVRHS, Analysis by MCH Epidemiology.

Narrative:
Please see narrative for Health Status Indicator 01A.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.3	1.4	1.3	1.3	1.3
Numerator	369	434	409	409	409
Denominator	29256	30567	30605	30605	30605
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 NMVRHS data are not yet available.

Notes - 2008
2008 NMVRHS data not yet avaiailable.

Notes - 2007
Source: NMVRHS, Analysis by MCH Epidemiology.

Narrative:
In 2007 409 infants under 1500 grams were born in New Mexico. This constituted 1.3% of the total live births in the state, slightly below the national average of 1.5%. This also constituted a steady state in the number of very low birthweight infants born in the state. Almost all very low birth-rate babies are premature, though they may also be growth restricted. Efforts to decrease the percent of live births weighing less than 1,500 grams, therefore, focus on prevention of premature births

1. The Maternal Health program has made efforts to stabilize and/or decrease the number of very low birthweight births by:

2. Recruiting and retaining a viable birthing services workforce in both rural and urban areas of the state through award and tax incentive initiatives designed to influence provider's ability and desire to practice obstetrics and midwifery in underserved locations

3. Maintaining funding for the High Risk Prenatal Fund which pays providers, clinics, hospitals, laboratories, ultrasonographers and social workers to provide prenatal care to high risk medically indigent pregnant women

4. Partnering with WIC and community agencies to enhance pre-conceptual counseling, inter-conceptual counseling, nutritional counseling, maternal depression screening and substance abuse screening

5. Disseminating evidence based data contraindicating elective inductions and cesarean sections based on consumer demand or provider convenience

6. Supporting and expanding care delivered by nurse-midwives and licensed midwives, whose services have been demonstrated to produce significantly fewer low-birth weight babies, due in part to their focus on prevention and nutrition, as well as reduction in use of unnecessary interventions

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.0	1.1	1.0	1.0	1.0
Numerator	289	324	316	316	316
Denominator	28518	29714	30369	30369	30369
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 NMVRHS data are not yet available.

Notes - 2008
2008 NMVRHS data not yet available.

Notes - 2007
Source: NMVRHS, Analysis by MCH Epidemiology.

Narrative:
Please see narrative for Health Status Indicator 02A.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	11.7	10.9	6.9	6.9	6.9
Numerator	48	45	28	28	28
Denominator	409523	411065	405808	405808	405808
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 NMVRHS data are not yet available.

Notes - 2007
Numerator: NMVRHS Analysis by MCH Epidemiology
Denominator: BBER

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
According to New Mexico Bureau of Vital Records and Statistics, from 2004-2007, 184 children under the age of 14 died from unintentional injuries, for a crude rate of 11.2. 41 fatalities in 2007 represent a 14% decrease from the previous three year average, and this was specific to the reduction in motor vehicle crash deaths, which may be due to the increased use of booster seats for ages 5-12. The new booster seat law in New Mexico, mandatory for children ages 5 and 6, or too small for adult belts up to age 12, went into effect in 2005.

The key causes of injury death differ by age. Birth defects and complications are the leading cause under the age of one month. Suffocation is the leading cause up to the age of 1 year. Motor vehicle crashes are the most frequent cause for every age group from the age of 1 to 24. Drowning, fires and burns are leading causes of injury death for children 9 years and younger. Other means of transport, including all terrain vehicles and bicycles, remain major causes for children ages 5-14 as well.

Title V funds support a full time childhood injury prevention coordinator position in the Office of Injury Prevention (OIP). Efforts by OIP and the New Mexico SAFE KIDS Coalition (NMSKC) are currently concentrating on revising and expanding the home safety curriculum for assisting young families and grandparents who care for small children. The home safety curriculum focuses on suffocation, fire, burn and drowning prevention, as well as many other related issues that are critical for infants and toddlers particularly.

Previous efforts by OIP and NMSKC led to the enactment of the Child Helmet Safety Act in 2007, requiring all minors to wear helmets while riding on non-motorized vehicles. OIP and NMSKC also played a pivotal role in the approval of the revised Off Road Vehicle Safety Regulations, enacted in 2006, requiring safety training and helmet use by all minors riding on motorized recreational vehicles. These two helmet laws, together with our primary, all positions and booster seatbelt laws, ranks NM among the best in the country for a legal framework targeting vehicle safety in every category.

NMSKC collaborates with the statewide SAFE KIDS network to implement all the vehicle laws and home safety education curriculum. The NMSKC is also increasing its collaboration with the Trauma Authority and expanding network of trauma centers statewide to provide funding for community safety events. The trauma centers in Alamogordo, Carlsbad, Roswell, Lovington, Santa Fe and Gallup are all official sponsors of local SAFE KIDS coalitions or chapters, while those located in Albuquerque and Farmington continue to be supportive members. There are also SAFE KIDS groups in Grants, Las Vegas, and Clovis, with organizational meetings in progress to provide for additional services in Taos and Espanola within the next year.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.1	6.6	6.4	6.4	6.4
Numerator	33	27	26	26	26
Denominator	409523	411065	405808	405808	405808
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 NMVRHS data are not yet available.

Notes - 2008
2008 data not yet available.

Notes - 2007
Numerator: NMVRHS
Denominator: BBER
Analysis by MCH Epidemiology.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
According to the New Mexico Bureau of Vital Records and Health Statistics, from 2004-2007, 101 youth under the age of 14 died as a result of a motor vehicle crash. The age-adjusted rate for this period was 6.2. Fortunately, the total number of fatalities in this age group in 2007 represented a 48% decrease from the average number of fatalities during the previous three years, which may be associated with the increase in the use of booster seats in the 5-14 age group since the enactment of the new booster seat law in 2005.
The car seat law had previously been expanded from being mandatory prior to age 1 to mandatory prior to age 5 in 2001. The NM booster seat law is mandatory for ages 5 and 6, and optional up to age 12 if the child is too small to be in an adult seat belt.

We are soliciting donations and volunteers to start new SAFE KIDS chapters in Taos and Rio Arriba Counties during the coming year, in addition to the 12 existing coalitions and chapters now in operation. Three organizational meetings have taken place in Taos, and one is planned for early summer in Espanola in conjunction with the skate park campaign and other events to prepare for next year. New Mexico continues to offer 16 mini-conferences per year to home daycare providers so that they can comply with certification requirements, and we provided home safety training at 4 of these conferences this year. We also expanded safety workshops to include the Region 6 Head Start Conference, the Albuquerque Area Early Head Start program, and the regional Native American Head Start programs, in addition to the first annual Home Visiting Specialists Conference for CYFD and workshops for Public Health Office employees.

If there is sufficient funding in the years to come, the home safety program will be expanded to include foster, adoptive, disabled and grandparents. New Mexico has currently expanded home visitation programs for new parents from 7 to 17 counties, with plans to go statewide over the next decade, receiving most candidates via the WIC services, which are now accessed by 46% of all mothers. Ongoing collaboration between the NMSKC and the SK network on the solicitation of funds from the New Mexico Trauma Authority will continue.

If there is sufficient funding, home safety education programs will be expanded to include some foster, adoptive, disabled and grandparents. In addition to providing safety workshops at the second annual Home Visiting Specialists Conference, it is anticipated that the NMSKC will target the 16 nonprofits currently contracting with CYFD individually for follow-up conferences in their respective communities, possibly in conjunction with local SK coalitions and chapters. The home safety education curricula always include in-depth coverage of car seat and booster seat installation.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	39.2	35.9	33.6	33.6	33.6
Numerator	119	111	107	107	107
Denominator	303556	309204	318276	318276	318276
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 NMVRHS data are not yet available.

Notes - 2007
Numerator: NMVRHS
Denominator: BBER
Analysis by MCH Epidemiology.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
According to the New Mexico Bureau of Vital Records and Health Statistics, from 2004-2007, 439 youth ages 15 - 24 died as a result of a motor vehicle crash. The age-adjusted rate for this period was 35.7. Fortunately, the total number of fatalities in this age group in 2007 represented a 13% decrease from the average number of fatalities during the previous three years. Hopefully this trend will continue.

In 2005, 15% percent of all drivers in crashes were young adult drivers, although young adults comprised only 9% of drivers here in New Mexico. 28% of crashes involving young adult drivers occurred at night, while only 26% of all crashes occurred at night. (Source: Division of Government Research, UNM, Traffic Safety Bureau)

Overall, New Mexico ranked 10th highest among states in seatbelt use in 2005 with 89.5% of front seat occupants wearing seatbelts. From 1983 to 1995, New Mexico seatbelt use increased dramatically and then continued a gradual increase to nearly 90% usage. Crash deaths decreased 30% during this same time period, and having both "primary" and "all positions, all the time" seat belt laws have been significant contributing factors.

MVC death rates and alcohol involved MVC death rates have decreased by 35% and 59%, respectively, from 1982 to 2004. Alcohol was involved in 10% of all MVCs causing injury or death in 2004. 42% of motor vehicle injury deaths in 2004 occurred in alcohol-involved crashes. A

more recent key intervention has been the adoption of ignition interlock laws, and New Mexico now has the most comprehensive interlock law in the nation, as well as worldwide.

According to the 2007 New Mexico Youth Risk and Resiliency Survey, 90% of high school students reported seatbelt use most or all the time. However, more than 30% of both male and female students reported that, in the past 30 days, they had ridden with a driver who had been drinking. A more recent emerging hazard of concern for youth particularly has been the use of cell phones while driving, and especially for the purpose of texting, as of course in addition to the distraction of phone conversation, requires visual attention as well. Cell phone use is now prohibited while driving in the municipalities of Albuquerque, Santa Fe and Las Cruces, and a new state law prohibiting texting while driving will be considered for a second time at the legislature in 2011.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	173.6	173.8	173.8	173.8	173.8
Numerator	711	769	769	769	769
Denominator	409523	442462	442462	442462	442462
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 injury data not yet available.

Notes - 2008
2008 injury data not yet available.

Notes - 2007
See note for 2006.

Hospital Discharge Data 2007 is not yet available.

Narrative:
According to New Mexico Bureau of Vital Records and Statistics, from 2004-2007, 2,771 children under the age of 14 were hospitalized for unintentional injuries, for a crude rate of 169.2. A total of 672 hospitalizations in 2007 represented a 4% decline from the average for the previous three years, but there is no indication of a downward trend because the volume of incidence in 2007 was slightly higher than in 2006.

Injuries are the leading cause of hospitalization in young children and youth. Injury prevention programs require strategies to reach parents and others who care for young children. Home visiting programs to educate new and young parents of small children about injury prevention is a

critical and permanent need, for which there is no substitute. A home safety check often reveals a significant life-threatening hazard that has been entirely unnoticed by the family, regardless of their previous orientation to safety education. This would include accessible tools, drugs, poisons, knives, guns, cosmetics, lighters, bodies of water and many other concerns, as well as overexposure to carbon monoxide, mold, dust, pesticides and other chemicals, which often results in asthma attacks and other severe allergic reactions.

Children under 14 years are five times more likely to be injured in bicycle-related crashes than older riders. According to the NM Brain Injury Advisory Council, between 70% and 80% of all fatal bicycle crashes involve brain injuries. Nationally, only 41% ages 5 to 14 wear helmets when participating in wheeled activities like biking and skateboarding, and 35% of children who use helmets wear them improperly, typically not using the chin strap. Bicycle helmets reduce the risk of head injury by as much as 85% and the risk of brain injury by as much as 88% if they are properly secured.

The incidence of brain injury has been reduced by as much as 45% in some of the states and municipalities with helmet laws for minors. New Mexico enacted a non-motorized vehicle helmet law in 2007 requiring children under 18 years to wear them while riding on bicycles, skateboards, skates, scooters and tricycles on public property, including sidewalks. This law is consistent with the revised off road vehicle regulations enacted in 2006, which require training certification and helmets for all minors riding on all terrain vehicles, off road motorcycles, snowmobiles and miniature "pocket" bikes.

Other prevention strategies include education and program support of public agencies, coalitions, and other organizations, including CYFD, HSD, DOT, Head Start, Early Head Start, the NM SAFE KIDS Coalition and statewide network of SAFE KIDS coalitions and chapters, the annual Home Visitors' Conference, and the Regional Child Care Educational Conference series for home daycare providers. This includes sharing of evidence-based prevention strategies, research, networking, and funding opportunities for childhood injury prevention programs.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	187.8	510.1	510.1	510.1	510.1
Numerator	769	2097	2097	2097	2097
Denominator	409523	411065	411065	411065	411065
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 injury data not yet available.

Notes - 2007

2007 & 2008 Vehicle Crash Injury Data are not yet available.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
According to New Mexico Bureau of Vital Records and Statistics, from 2004-2007, 2,771 children under the age of 14 were hospitalized for unintentional injuries, for a crude rate of 169.2. A total of 672 hospitalizations in 2007 represented a 4% decline from the average for the previous three years, but there is no indication of a downward trend because the volume of incidence in 2007 was slightly higher than in 2006.

Injuries are the leading cause of hospitalization in young children and youth. Injury prevention programs require strategies to reach parents and others who care for young children. Home visiting programs to educate new and young parents of small children about injury prevention is a critical and permanent need, for which there is no substitute. A home safety check often reveals a significant life-threatening hazard that has been entirely unnoticed by the family, regardless of their previous orientation to safety education. This would include accessible tools, drugs, poisons, knives, guns, cosmetics, lighters, bodies of water and many other concerns, as well as overexposure to carbon monoxide, mold, dust, pesticides and other chemicals, which often results in asthma attacks and other severe allergic reactions.

Children under 14 years are five times more likely to be injured in bicycle-related crashes than older riders. According to the NM Brain Injury Advisory Council, between 70% and 80% of all fatal bicycle crashes involve brain injuries. Nationally, only 41% ages 5 to 14 wear helmets when participating in wheeled activities like biking and skateboarding, and 35% of children who use helmets wear them improperly, typically not using the chin strap. Bicycle helmets reduce the risk of head injury by as much as 85% and the risk of brain injury by as much as 88% if they are properly secured.

The incidence of brain injury has been reduced by as much as 45% in some of the states and municipalities with helmet laws for minors. New Mexico enacted a non-motorized vehicle helmet law in 2007 requiring children under 18 years to wear them while riding on bicycles, skateboards, skates, scooters and tricycles on public property, including sidewalks. This law is consistent with the revised off road vehicle regulations enacted in 2006, which require training certification and helmets for all minors riding on all terrain vehicles, off road motorcycles, snowmobiles and miniature "pocket" bikes.

Other prevention strategies include education and program support of public agencies, coalitions, and other organizations, including CYFD, HSD, DOT, Head Start, Early Head Start, the NM SAFE KIDS Coalition and statewide network of SAFE KIDS coalitions and chapters, the annual Home Visitors' Conference, and the Regional Child Care Educational Conference series for home daycare providers. This includes sharing of evidence-based prevention strategies, research, networking, and funding opportunities for childhood injury prevention programs.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	2,212.1	2,009.4	2,009.4	2,009.4	2,009.4
Numerator	6715	6213	6213	6213	6213
Denominator	303556	309204	309204	309204	309204
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 injury data not yet available.

Notes - 2007
2007 traffic crash data are not yet available.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
According to the New Mexico Bureau of Vital Records and Health Statistics, from 2004-2007, 1,039 youth ages 15 - 24 were hospitalized as a result of a motor vehicle crash. The age-adjusted rate for this period was 84.5. Fortunately, the total number of injuries in this age group in 2007 represented a 15% decrease from the average number of fatalities during the previous three years.

In 2005, 15% percent of all drivers in crashes were young adult drivers, although young adults comprised only 9% of drivers here in New Mexico. 28% of crashes involving young adult drivers occurred at night, while only 26% of all crashes occurred at night. (Source: Division of Government Research, UNM, Traffic Safety Bureau)

Overall, New Mexico ranked 10th highest among states in seatbelt use in 2005 with 89.5% of front seat occupants wearing seatbelts. From 1983 to 1995, New Mexico seatbelt use increased dramatically and then continued a gradual increase to nearly 90% usage. Alcohol was involved in 10% of all MVCs causing injury or death in 2004. 42% of motor vehicle injury deaths in 2004 occurred in alcohol-involved crashes. A more recent key intervention has been the adoption of ignition interlock laws, and New Mexico now has the most comprehensive interlock law in the nation, as well as worldwide.

According to the 2007 New Mexico Youth Risk and Resiliency Survey, 90% of high school students reported seatbelt use most or all the time. However, more than 30% of both male and female students reported that, in the past 30 days, they had ridden with a driver who had been drinking. A more recent emerging hazard of concern for youth particularly has been the use of cell phones while driving, and especially for the purpose of texting, as of course in addition to the distraction of phone conversation, requires visual attention as well. Cell phone use is now prohibited while driving in the municipalities of Albuquerque, Santa Fe and Las Cruces, and a new state law prohibiting texting while driving will be considered for a second time at the

legislative session in 2011.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	31.5	36.7	30.2	30.2	30.2
Numerator	2335	2750	2469	2469	2469
Denominator	74172	75026	81814	81814	81814
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not yet available.

Notes - 2008
2008 data are not yet available.

Notes - 2007
Numerator Source: NM DOH STD program
http://www.health.state.nm.us/std/pdf/ChlamydiaCasesAgeSexCounty07.pdf

Denominator Source: UNM Bureau of Business and Economic Research 2007 population estimate

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
In 2009, there were 9,458 reported chlamydia morbidities in New Mexico, 73.2% of them among females. In females, 72% of all the morbidities were in those aged 24 and under, and the 15-19 age group was second highest with 33.8% of the total for females. Clearly, this is a high-risk group. The total number of cases has remained flat for the past 5 years, indicating that perhaps the spread has been checked at least in part due to widespread testing, treatment and prevention efforts.

The chlamydia testing in the FPP-funded clinics is part of the statewide infertility prevention project funded by Center for Disease Control and Prevention (CDC). The annualized (based on actual data from 3 quarters) number of tests performed in both STD and Family Planning clinics for 2009 was 35,623, with 11.0% positivity. Among females aged 15-19, the rate of positivity was 11.9%. This age group of females made up 20% of all those tested (5,224 individuals). The Family Planning and STD Programs are working hard to more effectively target screening

towards the high-risk groups and especially females age 25 and under in accordance with national guidelines.

The New Mexico Department of Health prioritizes screening of all females age 25 and under to prevent PID, infertility, ectopic pregnancy and other complications. It does this statewide both internally and also working with private providers, where 70% of the STD morbidities within the state are identified and treated. Looking at this big picture, the Department has direct control over part of the health care system and only indirect influence over another part.

Strategies to improve screening and treatment for this age group are:

-Maintain provider agreements with selected school based health centers to support testing efforts,

-Monitor data to target at least 75% of screening paid for by DOH is used on females under age 25,

-Work with New Mexico Medical Society on Clinical Preventive Initiative aimed at increasing the percentage of providers who perform routine annual screening on all females under 25 statewide,

-Promote the use of Expedited Partner Therapy (patient delivered partner therapy) to reduce the incidence of re-infection after treatment,

-The Office of Adolescent Health is launching a study of social marketing targeting adolescents with the idea of creating effective messages to encourage screening.

-Screening is taking place in several youth corrections facilities, and very high positivity rates are resulting compared to the general population.

According to the YRRS (Youth Risk and Resiliency Survey) 2007, 45.7% of New Mexico high school students had "ever" had sexual intercourse, while almost one third of students (31.5%) reported being currently sexually active. 44.8% did not use condom the last time they had sexual intercourse. This indicates high numbers of young women at risk for chlamydia in a state with high morbidity rates.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.9	36.2	33.5	33.5	33.5
Numerator	2266	2722	2491	2491	2491
Denominator	329938	75171	74291	74291	74291
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not yet available.

Notes - 2008
2008 data not yet available

Notes - 2007
Numerator Source: NM DOH STD program
http://www.health.state.nm.us/std/pdf/ChlamydiaCasesAgeSexCounty07.pdf

Denominator Source: UNM Bureau of Business and Economic Research 2007 population estimate.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
The chlamydia testing in the FPP-funded clinics is part of the statewide infertility prevention project funded by Center for Disease Control and Prevention (CDC). The annualized (based on actual data from 3 quarters) number of tests performed in both STD and Family Planning clinics for 2009 was 35,623, with 11.0% positivity. Among females aged 20-24, the rate of positivity was 10.8%. This age group of females made up 23% of all those tested (6,172 women). The Family Planning and STD Programs are working hard to more effectively target screening towards the high-risk groups and especially females age 25 and under in accordance with national guidelines.

In 2009, there were 9,458 reported chlamydia morbidities in New Mexico, 73.2% of them among females. In females, 72% of all the morbidities were in those aged 24 and under, and the 20-24 age group was highest with 36.8% of the total for females. Clearly, this is a high-risk group. The total number of cases has remained flat for the past 5 years.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	26722	21993	700	3573	456	0	0	0
Children 1 through 4	100488	82352	2668	13821	1647	0	0	0
Children 5 through 9	122786	98607	4511	17164	2504	0	0	0
Children 10 through 14	160999	127755	5412	25097	2735	0	0	0
Children 15 through 19	166877	135934	5296	22787	2860	0	0	0
Children 20	152891	124255	5346	20703	2587	0	0	0

through 24								
Children 0 through 24	730763	590896	23933	103145	12789	0	0	0

Notes - 2011

Narrative:
The University of New Mexico's Bureau of Business and Economic Research (UNM BBER) uses US Census data to create population estimates for New Mexico. UNM BBER data show that in 2007 the total population of children age 0-19 in New Mexico was 573,168, representing 28% of the total population.

In 2007 a press release from the US Census Bureau noted that New Mexico is one of four states, and the District of Columbia, that is "majority-minority" with 57% of its population being classified as "minority." There are 51.5 % Hispanic children, 13.2% American Indian-Alaska Natives children, 2.2% Black-African American children, 1.3% Asian-Pacific Islander, and Non-Hispanic White children making up only 31.7% of the population.

New Mexico has the second highest proportion of Native Americans in the US, and is projected to have the third highest number of Native Americans within the next 20 years.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	12440	14282	0
Children 1 through 4	47184	53304	0
Children 5 through 9	56251	66535	0
Children 10 through 14	78775	82224	0
Children 15 through 19	86844	82654	0
Children 20 through 24	77773	75118	0
Children 0 through 24	359267	374117	0

Notes - 2011

Narrative:
Hispanic children constitute roughly half of the population of children in New Mexico.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live	**Total All**	**White**	**Black or African American**	**American Indian or Native**	**Asian**	**Native Hawaiian or Other**	**More than one race**	**Other and Unknown**

births	**Races**			**Alaskan**		**Pacific Islander**	**reported**	
Women < 15	29	15	2	7	0	0	0	5
Women 15 through 17	1963	1644	35	240	0	4	0	40
Women 18 through 19	3874	3191	83	504	1	11	0	84
Women 20 through 34	27498	23118	472	3064	80	323	0	441
Women 35 or older	3838	3221	52	426	32	62	0	45
Women of all ages	37202	31189	644	4241	113	400	0	615

Notes - 2011

Narrative:
There were 30,605 births to New Mexico resident mothers in 2007, translating to a birth rate of 14.9 births per 1,000 population. New Mexico's birth rate has declined from a rate of 19.1 in 1985. In 2006, the national birth rate was 14.2, a slight increase from the 2002 birth rate of 13.9, a record low for the United States. The state birth rate has been consistently higher than the national rate, although since 2000 New Mexico's rate has dropped closer to that of the United States.

Of New Mexico's 33 counties, eleven had birth rates higher than the 2007 state rate of 14.9. Lea County had the highest birth rate in the state at 21.0. New Mexico's fertility rate has increased 14.5% between 2006 and 2007. In 2007, Hispanic mothers had the highest fertility rate (86.6), the highest percent of births (54.3), and the highest birth rate (19.6) among the state's racial/ethnic groups in New Mexico. The birth rate for American Indians was 17.3, for Asian/Pacific Islanders, 14.6, and for African Americans, 11.7.

Strategies to decrease teen birth rate and births to single mothers in NM have met with mixed success. The NM Prenatal Care Utilization task force and the NM Young Fathers Project aim to promote public awareness by sending messages to delay parenthood until education has been completed and employment has been established. Ten NM Public Health Offices and 3 school based clinics offer family planning services including low cost and no cost contraception options. Abstinence only education is slowly being replaced by evidenced based sexual education including accurate information about contraception and condom use. Focused needs assessment involving Native American and Hispanic youth indicate a need for increased access to comprehensive pregnancy prevention education, community-based programs and contraceptives.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	13	58	2
Women 15 through 17	487	1149	8
Women 18 through	1132	2029	30

19			
Women 20 through 34	10513	12470	135
Women 35 or older	1807	1404	10
Women of all ages	13952	17110	185

Notes - 2011

Narrative:
In 2007, Hispanic mothers had the highest fertility rate (86.6), the highest percent of births (54.3), and the highest birth rate (19.6) among the state's racial/ethnic groups in New Mexico.

Women identified as Hispanic or self-identifying as Hispanic are by far the largest population of childbearing women in New Mexico. Efforts to provide culturally relevant care for these women are multifaceted. Women may not be motivated to seek care, especially for unintended pregnancies. Societal and maternal reasons cited for poor motivation include fear of medical procedures or disclosing pregnancy to others, depression, and a belief that prenatal care is unnecessary. Structural barriers include long wait times, the location and hours of clinics, language and attitude of the clinic staff, cost of services and a lack of child-friendly facilities.

The Maternal Health Program (MH) focuses cultural competency in prenatal care (PNC) on meeting the needs of Hispanic and Native American women. The ten Public Health Offices providing PNC each have Spanish-speaking clinical staff or expert translation available for clients. A Nurse Practitioner and Physician both originally from Mexico serve three of these ten clinics. Maternal Health contractors provide Spanish-speaking clinical staff and/or expert translation for Spanish speaking clients and other non-English speaking clients. Printed client education resource materials provided by MH are made available in both English and Spanish.

Focus groups of Hispanic and Navajo women, young and old, urban and rural, have guided PNC promotion. MH actively promotes the model of Centering Pregnancy, a facilitated group PNC approach, designed to improve cultural relevance for all women. This model has been proven to increase satisfaction with and attendance at PNC, as well as self-care and breastfeeding. MH assisted six clinics develop Centering groups for Spanish-speaking women. Two agencies in Albuquerque provide Centering care exclusively for teen mothers, their partners and support persons. MH, Public Health Offices, and community partners continually collaborate to identify cultural barriers to PNC, and to eliminate them.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	189	140	10	34	1	0	0	4
Children 1 through 4	51	36	2	13	0	0	0	0
Children 5 through 9	23	19	0	4	0	0	0	0
Children 10 through 14	27	20	1	6	0	0	0	0

Children 15 through 19	145	107	7	26	2	0	0	3
Children 20 through 24	199	136	7	49	4	1	0	2
Children 0 through 24	634	458	27	132	7	1	0	9

Notes - 2011

Narrative:
Infant deaths are a critical indicator of a state's wellbeing. The Healthy People 2010 goal is to reduce the infant mortality rate (IMR) to 4.5/1,000 live births; the neonatal mortality rate to 2.9/1,000 live births; & the post-neonatal mortality rate to 1.5/1,000 live births. The NM infant mortality rate (IMR), as well as the neonatal and post-neonatal mortality rates, has been at or lower than the national rate since 1980 with the exception of 1994.

Efforts continue to assure preconception and prenatal care for women in New Mexico to ensure healthy births. The 2011 NM Dept. of Health Strategic Plan includes 2 new objectives: Individual Health Objective 3: Increase the proportion of new mothers who had recommended levels of health care before, during & after pregnancy to assure optimal physical, mental & oral health & Community Health Objective 4: Reduce intentional & unintentional injury that contribute to the death of children. The New Mexico SAFE KIDS Coalition (NMSKC) network collaborates with Safer New Mexico Now (SNMN) on the training of child car seat technicians & production of child car seat clinics. NMSKC purchases & distributes bicycle helmets statewide. SAFE KIDS representatives teach home safety workshops at the 16 annual Regional Early Care Education conferences throughout New Mexico.

According to New Mexico Bureau of Vital Records and Statistics, from 2004-2007, 184 children under the age of 14 died from unintentional injuries, for a crude rate of 11.2. Forty-one fatalities in 2007 represent a 14% decrease from the previous three year average, and this was specific to the reduction in motor vehicle crash deaths, which may be due to the increased use of booster seats for ages 5-12. The new booster seat law in New Mexico, mandatory for children ages 5 and 6, or too small for adult belts up to age 12, went into effect in 2005.

The key causes of injury death differ by age. Birth defects and complications are the leading cause under the age of one month. Suffocation is the leading cause up to the age of 1 year. Motor vehicle crashes are the most frequent cause for every age group from the age of 1 to 24. Drowning, fires and burns are leading causes of injury death for children 9 years and younger. Other means of transport, including all terrain vehicles and bicycles, remain major causes for children ages 5-14 as well.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	75	108	6
Children 1 through 4	25	26	0
Children 5 through 9	12	11	0
Children 10 through	13	14	0

14			
Children 15 through 19	58	85	2
Children 20 through 24	115	82	2
Children 0 through 24	298	326	10

Notes - 2011

Narrative:
In 2008, the number of deaths of Hispanic infants in New Mexico (NM) was 89/100,000 population out of 152/100,000 population infant deaths. For NM Hispanic children/youth ages 1-24, the number of deaths was 192/100,000 population out of 371/100,000 population deaths. For NM Hispanic children ages 1-14, the number of deaths was 41/100,000 population out of 83/100,000 population deaths. Among NM Hispanic youth ages 15-24 the number of deaths was 140/100,000 population out of 288/100,000 population deaths.

In the 2007 YRRS, The percentage of youth reporting three important risk behaviors that contribute to unintentional injury has decreased since 2003: rarely or never wearing a seatbelt while riding in a car driven by someone else (11.5% in 2003 vs. 8.9% in 2007), riding with a drinking driver in the past 30 days (34.9% in 2003 vs. 31.2% in 2007), and drinking and driving in the past 30 days (19.1% in 2003 vs. 12.5% in 2007). For each of these measures, the decrease in the rate occurred largely between 2003 and 2005, while the 2007 rate remains similar to the 2005 rate.

The Child Health Program, through Project LAUNCH, provided a Child Care Health Consultant (CCHC) Coordinator to train others to perform the CCHC services of working with Child Care providers to improve the early childhood environments and the health of children in those settings. Child care environments present incredible opportunities to improve health outcomes for large numbers of children at a time, the primary goal for population based public health. Child care environments serve as ideal settings to teach children about healthy behaviors such as hand-washing, preventing obesity, preventing injuries, & healthy eating that will help them lead healthier lives. CCHCs also help providers and families recognize a child's targeted developmental stages & how to address possible developmental delays.

The NM Dept. of Health Strategic Plan for 2011 has added an Objective Strategy to create policies that reduce injuries & change attitudes that may lead to them. Injuries are the leading cause of death in NM among people ages 1 to 44. Community Health Objective 4 would investigate child deaths to identify & promote changes in systems, policies & programs that reduce preventable child injuries & deaths.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data	**Total All**	**White**	**Black or African**	**American Indian or**	**Asian**	**Native Hawaiian**	**More than**	**Other and**	**Specific Reporting**

BY RACE	**Races**		**American**	**Native Alaskan**		**or Other Pacific Islander**	**one race reported**	**Unknown**	**Year**
All children 0 through 19	580493	466641	18587	85063	10202	0	0	0	2008
Percent in household headed by single parent	26.7	19.0	43.1	0.0	0.0	0.0	17.7	34.8	2007
Percent in TANF (Grant) families	12.8	4.9	3.2	1.8	1.6	0.0	1.3	0.0	2008
Number enrolled in Medicaid	378254	295332	7679	65845	2199	0	0	7199	2009
Number enrolled in SCHIP	17189	13882	230	2942	115	0	0	20	2009
Number living in foster home care	1845	1457	111	277	0	0	0	0	2009
Number enrolled in food stamp program	136794	115180	3830	16142	1368	0	274	0	2008
Number enrolled in WIC	70371	62929	1378	2895	428	43	2698	0	2008
Rate (per 100,000) of juvenile crime arrests	23020.0	5128.0	651.0	1471.0	35.0	16.0	0.0	15719.0	2009
Percentage of high school drop-outs (grade 9 through 12)	4.5	82.0	3.2	25.5	0.9	0.0	0.0	0.0	2008

Notes - 2011
Source: National Survey of Children's Health
http://nschdata.org/DataQuery/DataQueryResults.aspx

Percent of children in "Mother-only household with no father of any type present."

"White" is White and Hispanic, all other races are non-Hispanic.

Non-Hispanic Asian, AINA, Native Hawaiian, or Pacific Islander are grouped by NSCH as "Other" because of small samples sizes.

The number by race of TANF children is estimated based on the percent by race of head of houshold in TANF families. That number is the numerator and BBER data is the denominator.

For example: TANF reports that 90% of its head of household recipients are White. There were 25,136 TANF children. 90% of 25136 = 22622 White child recipients. BBER estimates that there are a total of 459,634 White children ages 0-19. 22,622 is 4.9% of 459,634, therefore 5% of White children are in TANF families.

Source: Medicaid Report number AH100589 FFY08

Medicaid report combines "Asian" and "Native Hawiian/Other Pacific Islander, " and also combines "More than one race reported" and "Other and Unknown." Medicaid report distinguishes between "Caucasian" and "Hispanic" which are combined as "White" on this form.

Source: Medicaid Report number AH100589 FFY08

Medicaid report combines "Asian" and "Native Hawiian/Other Pacific Islander, " and also combines "More than one race reported" and "Other and Unknown." Medicaid report distinguishes between "Caucasian" and "Hispanic" which are combined as "White" on this form.

Food Stamp information is reported in percentages. Numbers are estimated based on race of head of household food stamp recipients. For example: It was reported that 84.2% of Food Stamp recipient heads of household were White. There were 136,794 individual child recipients of Food Stamps. 84.2% of 136,794 = 115,180 White child Food Stamp recipients.

For number of children enrolled in WIC: Data Note for title V MCH: These are calendar year 2008 WIC data for clients who were actually seen in 2008 in contrast to those who had a certification period that began, ended or continued in 2008 but who may not have been seen. There were an additional 10,970 who had an active certification but who were not seen; these include children who reached 5th birthday, moved or dropped out of WIC. There is an under-count of infants who were born in November and December 2008 due to unresolved issues in the programming to abstract records from the WIC system. It's estimated that the undercount was on the order of 1500 infants. This under-count has been present in all previous years as well; and will be resolved in the coming year.

Other and Unknown = 15719 beacause Juvenile Justice does not subset Hispanic ethnicity by race.

HIgh School dropout numbers: (First number is percent of enrollees that dropped out, subsequent numbers should be read as "percent of dropouts that were X race")

White = 3715
Black = 143
AINA = 1149
Asian/Native Hawaiian/Other Pacific Islander = 40
Total dropouts = 4507
Total Enrollment 2006-2007 was 100,134 for grades 9-12 (2007-2008 total enrollment numbers not available at this time.

Department of Education did not report "More than one race" or "Other and Unknown"

Source: New Mexcico Children, Youth and Families Department

Narrative:
The Human Services Department of the State of the NM Monthly Statistical Report for 8/2009 provides the following data:

The Supplemental Nutrition Assistance Program (SNAP) has the following demographic profile: 2.9% of the infants & children enrolled are from African American households, 1% are from Asian/Pacific Islander households, 12.5% are from Native American households, 83.4% are from Caucasian households.

The Temporary Assistance for Needy Families (TANF) has the following demographic profile:

3.6% of the infants & children enrolled are from African American households, 0.8% are from Asian/Pacific Islander households, 5.7% are from Native American households, 89.7% are from Caucasian households.

The Key Quarterly Performance Measures Report for the 3rd Quarter, Fiscal Year 2009 from www.cyfd.org provided the following data:

The Early Childhood Services Program focuses on Pre-K, quality child care, family nutrition, home visiting, & other early childhood development programming.

New Mexico Pre-K children enrolled are 59% Hispanic, all races, 22.4% American Indian & Alaska Native, 15.3% Caucasian, 1.3% Asian, % 1.2% Black.

The 2007-2008 New Mexico Head Start Information Report stated that there were 8,453 children enrolled in Early Head and Head Start. The children's ethnicity & race were as follows: Hispanic or Latino Origin-71.6%, Non Hispanic/Non Latino Origin-28.3%, American Indian/Alaska Native -.075%, Asian -.003%, Black or African American- .021%, biracial or multi-racial,.012 %.

Protective Services (PS) protects children & enhances the family's capacity to provide for the safety & well-being of their children. Through a statewide centralized call center, PS receives allegations of child maltreatment on a 24 hours a day basis at (800)797-3260. PS investigates allegations of child abuse & neglect & provides services, including in-home voluntary services, to ensure the safety, permanency & well-being of the child. When necessary for the safety of the child, PS provides foster care & adoptive services for children. In addition, PS provides other services for specialized family needs, including independent living services for youth involved in the foster care system. As of 12/31/09 there were 1844 children from 0-18 living in foster care homes. 79% of the children were white, 6% were black, & 15% were Indian or Native Alaskan. The total ethnicity rates were 59% Hispanic or Latino & 39% total not Hispanic or Latino, with 2% unknown.

New Mexico is facing challenging economic conditions. Through the New Mexico Children's Cabinet, an Investment Committee has been formed to create resourceful & innovative solutions to our high rates of poverty, especially children living in families at or below the federal poverty level. Through public/private partnerships a commitment has been made that every child from birth to 21 years of age will be healthy, educated, safe, supported & involved.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	281494	298999	0	2008
Percent in household headed by single parent	27.7	22.8	0.0	2007
Percent in TANF (Grant) families	2.6	5.9	0.0	2008
Number enrolled in Medicaid	71352	223980	7199	2009
Number enrolled in SCHIP	3899	9983	20	2009
Number living in foster home care	719	1088	37	2009
Number enrolled in food stamp program	83033	53760	0	2008
Number enrolled in WIC	14831	55400	140	2008

Rate (per 100,000) of juvenile crime arrests	7632.0	15147.0	241.0	2009
Percentage of high school drop-outs (grade 9 through 12)	28.5	71.4	0.0	2008

Notes - 2011
For number of children enrolled in WIC: Data Note for title V MCH: These are calendar year 2008 WIC data for clients who were actually seen in 2008 in contrast to those who had a certification period that began, ended or continued in 2008 but who may not have been seen. There were an additional 10,970 who had an active certification but who were not seen; these include children who reached 5th birthday, moved or dropped out of WIC. There is an under-count of infants who were born in November and December 2008 due to unresolved issues in the programming to abstract records from the WIC system. It's estimated that the undercount was on the order of 1500 infants. This under-count has been present in all previous years as well; and will be resolved in the coming year.

28.5 percent of dropouts were not Hispanic, 71.4 percent of dropouts were Hispanic.

Source: New Mexico Children, Youth and Families Department

Narrative:
The Supplemental Nutrition Assistance Program (SNAP) has the following ethnicity profile: 59.9% of those infants and children are of Hispanic or Latino ethnicity and 40.1% not Hispanic or Latino.

The Temporary Assistance for Needy Families (TANF) has the following ethnicity profile: 71.3% of those infants and children are of Hispanic or Latino ethnicity and 28.7% not Hispanic or Latino.

For the 2006-2007 school year, the percentage of New Mexico Pre-K children in each ethnic category is as follows: Hispanic, all races, 59%; American Indian and Alaska Native, 22.4%; Caucasian. 15.3%; two or more races, Asian 1.3%; and Black, 1.2%.

During the calendar year 2008, 1,337 New Mexico children had adoption as a permanency goal. As of December 31, 2008, 511 children were legally free to be adopted. Of those legally freed, 222 children were in adoptive family homes and had an adoptive agreement signed and in effect. Of the 1,337 children with adoptive plans, 58% were of Hispanic or Latino ethnicity, with 40% non-Hispanic or Latino ethnicity, 2% are unknown.

The ethnicity of children 0-18 years of age living in foster care homes was a total Hispanic or Latino of 59%, total not Hispanic or Latino was 39% with 2% unknown.

The Juvenile Justice Services Statistical Abstract reports that children in New Mexico, (age 10-17), at risk are 49.8% Hispanic or Latino.

For purposes of comparison, New Mexico-specific estimates from the NM 2010 Children's Cabinet Report Card & Budget Report show that the percentage of New Mexico children in each ethnic category is as follows: Hispanic, all races, 51.5%; non Hispanic White, 31.7%; American Indian and Alaska Native, 13.2%; Black African Americans, 2.2%; and Asian- Pacific Islanders, 1.3%.

Poverty in the early years of a child's life, more than at any other time, has especially harmful effects on continuing healthy development and well-being, including developmental delays and infant mortality. Well-being in later childhood, such as teen pregnancy, substance abuse, and educational attainment, are also influenced by early childhood poverty. Children born into poverty are less likely to have regular health care, proper nutrition, and opportunities for mental

stimulation and enrichment.

New Mexico is committed to making strategic investment that will have a lasting and significant impact on our state. The Children's Cabinet is committed to improving each New Mexico child's life and opportunities for success through innovative policies, wise investments, expansion of access of services, and development of partnerships among state agencies, non-profit and philanthropic organizations.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	287332
Living in urban areas	167804
Living in rural areas	358298
Living in frontier areas	37296
Total - all children 0 through 19	563398

Notes - 2011
Approximately 51% of children 0-19 live in metropolitan areas in New Mexico.

Frontier includes "Sub-Frontier"

Narrative:
Fourteen of New Mexico's 33 counties are considered "Frontier" or "Sub-Frontier." Eighteen counties are "Rural" and one is "Urban." US Census Bureau Data Set: 2008 Population Estimates show county populations of children ages 0-19 ranging from 101 in Harding county to 174,674 in Bernalillo county.

Six counties have a population density per square mile of 10 or above. The remaining 27 have population densities of 9.2 or less. The range is <0.1 children aged 0 through 19 years per square mile in Harding County to 149.4 children per square mile in Bernalillo County.

Geographic distance has long been recognized as a barrier to health care access for New Mexicans. The 2011 NM DOH Strategic Plan identifies two health system objectives that address this issue: "Improve recruitment, retention and training of health care providers in rural, American Indian and border communities" and "Increase use of technologies to improve health outcomes." Some of the strategies to achieve these objectives are:

1. Continue to standardize and streamline health professional licensing processes in New Mexico, including reciprocity where appropriate.

2. Consider strategies to improve healthcare provider compensation rates in New Mexico to remain competitive with rising compensation rates in surrounding states.

3. Explore the leverage of state funding with available federal and foundation grant funding to provide additional incentives for faculty recruitment and retention in health professional education programs within the state.

4. Study programming available through telehealth networks to increase access to health services in rural areas of the state and support the use of electronic medical records.

5. Continue to explore increased opportunities for training and rural residency sites in the Department's Public Health Offices for health professionals.

6. Work to increase the use of allied professionals to deliver services.

7. Build infrastructure throughout DOH to support advancing technology (electronic medical records, telehealth, video conferences) and to ensure adequate and reliable network connections.

8. Improve all DOH websites.

9. Maintain inventory of current telehealth services, sites and resources.

10. Develop a comprehensive health data management system that geo-codes health data for surveillance, incorporating aspects of NM-EDSS, the IBIS system, Environmental Health Tracking System, and other relevant modules to improve targeting of public health resources.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2080048.0
Percent Below: 50% of poverty	7.3
100% of poverty	22.0
200% of poverty	38.7

Notes - 2011
Percent report of below 100% poverty is actually below 125% of poverty.

Narrative:
The New Mexico Voices for Children Kids 2009 report highlights the discrepancies between those that are considered living under the poverty level and those that are technically above it but still struggling to get by. The percentage of children that are considered to be "living below poverty" may not accurately reflect just how many children live in families that are struggling to meet their basic needs. While the official poverty measure, commonly referred to as the federal poverty level (FPL), is supposed to indicate how much it costs a family to live at a bare minimum, by many accounts the actual costs are roughly twice the FPL. People who fall below the official poverty level are deemed "poor." This leaves open the assumption that anyone making more than the FPL are "not poor."

Problematically, the poverty measure does not take geographical location or family configurations into consideration, which means that the FPL is the same for a family in the inner-city where costs are high and for a family living in a rural area with relatively lower costs. All of these factors make it very difficult for families to provide the basic necessities for their children, let alone improve their situation, even when they live at 200 percent -- or double -- the official FPL.

The Basic Family Budget gives a more realistic measure of how much it costs to support a family. Seven expenditures are included in this budget: housing, food, child care, transportation, health care, other necessities, and taxes. Basic Family Budgets are calculated for communities all across the U.S. for six family types--one- and two-parent families with one, two, and three

children. In New Mexico, budgets are available for Albuquerque, Las Cruces, Santa Fe, and Farmington. Source: http://www.nmvoices.org/attachments/nm_kc_08_essay.pdf//2010//

In many parts of New Mexico, it costs more than twice the FPL for families to provide the basics for their children. Over the years, wages have not kept up with inflation, and hence, paychecks have not stretched as far to pay for the rising cost of necessities. Families that were struggling before the current economic slump are likely to feel the pressure on their budgets even more acutely now.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	466641.0
Percent Below: 50% of poverty	10.7
100% of poverty	27.7
200% of poverty	23.4

Notes - 2011

Narrative:
In many parts of New Mexico, it costs more than twice the federal poverty level (FPL) for families to provide the basics for their children. Over the years, wages have not kept up with inflation; therefore, paychecks do not stretch as far to pay for the rising cost of necessities. Families that struggled before the current economic recession are likely to feel the pressure on their budgets even more acutely now.

Only five states have higher rates of poverty than New Mexico. The New Mexico Voices for Children Kids Count 2009 report highlights the discrepancies between those that are considered living under the poverty level and those that are technically above it but still struggling to get by. Most New Mexicans considered low-income are "working-poor" -- meaning at least one family member works, usually in a low-wage job. More than one-third of New Mexico's jobs are low-wage and offer few benefits, such as health insurance or retirement. The percentage of children that are considered to be "living below poverty" may not accurately reflect just how many children live in families that are struggling to meet their basic needs. While the official poverty measure is supposed to indicate how much it costs a family to live at a bare minimum, by many accounts the actual costs are roughly twice the FPL. People who fall below the official poverty level are deemed "poor." This leaves open the assumption that those making more than the FPL are "not poor."

The poverty measure is inadequate for assessing a sufficient standard of living for families. In addition to food, child care is a major expense for working families, as well as housing, transportation, and health care, all of which families need to survive, though not calculated in the measure.

Problematically, the poverty measure does not take geographical location or family configurations into consideration, which means that the FPL is the same for a family in the inner-city where costs are high and for a family living in a rural area with relatively lower costs. All of these factors make it very difficult for families to provide the basic necessities for their children, let alone improve their situation, even when they live at 200% -- double -- the official FPL.

25.4% of the total population in New Mexico is children ages 0-17. The percentage of families in New Mexico with related children (ages 0-17) living below poverty is 10.4% (married couple families) and 44.1% (single-mother families.)

F. Other Program Activities

IV. F. 1. Maternal and Child Health

NM Title V Program and MCH staff are working to develop a comprehensive state-level multi-agency service system, which reaches to the community-level and will support families in fostering the healthy development of their children. The Early Childhood Comprehensive Systems (ECCS) grant and Project LAUNCH provide opportunities to supplement the systems development work of the State Title V Program. Through the ECCS grant, a state-level Early Childhood Coordinator was hired to align and coordinate all state-level early childhood programs and services to create an effective and efficient structural, functional, and operational system to offer early childhood services for children, birth through eight, and their families. The ECCS grant funded the 6th annual Family Leadership Conference (FLAN) in April, with an attendance of approximately 200. Through Project LAUNCH, the MCH Health Educator has received training as a certified Child Care Health Consultant (CCHC) Trainer and will contribute time to build the CCHC system in NM and train others as consultants. Other new collaborative efforts include the Maternal Depression Working Group (MDWG) pilot project to identify women at risk for perinatal depression, and REEL Fathers, which uses the power of cinema and reflective activities to honor and celebrate involved fathers, and to heal, renew, and deepen the lifelong connections between fathers and their children -- supporting stronger, more stable family relationships. Additionally, by linking with public/private partners and other early childhood collaborative efforts, the First Five Years Fund video "Change the First Five Years and You Change Everything" was edited to be specific for a NM audience. A link to the video can be found at www.earlychildhoodnm.com. Working with Kiwanis, the previously mentioned website will be revamped to be interactive and expand the scope of the site. Another exciting new state-wide collaboration includes the NM Alliance for Fathers and Families, which is helping to plan a White House Community Roundtable and Town Hall Meeting on Responsible Fatherhood and Healthy Families, co-sponsored by the White House Office of Faith-based and Neighborhood Partnerships and USDA Rural Development.

Families FIRST received funding from the Human Services Dept. to pilot a program on Perinatal Depression Screening. Working in conjunction with the WIC Program in the Santa Fe and Las Vegas Public Health Offices, we are screening pregnant and post-partum women with the Edinburgh Screening Tool. This will highlight the % of perinatal depression and will provide a referral resource list for women experiencing maternal depression.

Senate Memorial 28: Adolescent Birth Rate Reduction Task Force, passed in 2010, is to enhance collaboration for teen pregnancy prevention activities and continue strategic targeting of resources towards evidence-based programming. The task force met in April 2010. The consensus was that teen pregnancy prevention groups in NM should continue to follow the five strategies for teen pregnancy prevention (family planning clinical services, comprehensive sex education, service learning programs, adult-teen communication programs and male involvement programs).

IV. F. 2. Children's Medical Services (CMS)

The Medical Director for CMS, the Title V Program for Children and Youth with Special Health Care Needs, serves on the Multi-Agency Team Council on Young Child Wellness, which is part of

the ECCS project. The Title V Special Needs Director and the CMS Medical Director serve on the LEND Advisory Committee. The CMS Medical Director also serves on the Autism Advisory Board of the Center for Development and Disability (CDD) at the University of New Mexico.

A team consisting of the acting CMS Statewide Program Manager, the CMS Medical Director, and some of the regional Program Managers and Supervisors has been working on a white paper which will explain why the program is structured as it is, describe the work of medical social work and care coordination, and detail the value of care coordination in containing health care costs and improving patient care and family satisfaction with services they receive. We are planning to present the white paper to the division leadership and hopefully publish it as well.

CMS is also in the planning stages of developing two research projects to evaluate the quality of services provided to CYSHCN. Both projects will involve reviewing client records. The first project will look at a randomized sampling of Medicaid clients from each region, for whom CMS social workers provide care coordination services, to see whether they are obtaining the required EPSDT services such as hearing and vision screening. A recent report from the Office of the Inspector General at HHS showed that 76% of Medicaid clients do not get the recommended EPSDT services. This triggered interest in evaluating how our CMS clients are doing with these screenings.

The second project will focus on children with cleft lip and/or palate to determine from record review whether they are receiving surgeries and other services at the recommended times according to national standards published by the American Cleft Palate and Craniofacial Association. We will start by reviewing records of CMS clients with cleft lip and/or palate who were born between Jan. 1, 1995 and Jan. 1, 2009. If possible we will expand to evaluate non-CMS clients in NM as well. This project will be very time intensive and feasibility will depend on staff availability as there is no funding available at this time to pay an abstractor or contractor.

Toll-Free Nurse Advice Hotline

In 2007, New Mexico launched a 24-hour Nurse Advice Line for all New Mexicans. The number is 877-725-2552. Nurse Advice was the first public-private, health advice line in the nation. Thirty-eight nurses, totaling 15 full-time-equivalent positions, staff the line, answering healthcare questions and directing callers to local community resources. The New Mexico Department of Health provided $500,000 in startup funding, which was supported by the New Mexico Legislature. Supporting organizations are University of New Mexico, Presbyterian Health Plan, Coordinated Systems of Care, Community Access Program, Lovelace Health Plan, Primary Care Association, Bernalillo County and New Mexico Hospital and Health Systems Association.

G. Technical Assistance

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4439493	4331887	4331887		4331887	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	6951988	2813289	3652913		3248916	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	11391481	7145176	7984800		7580803	
8. Other Federal Funds *(Line10, Form 2)*	56786600	54285700	63535200		54285700	
9. Total *(Line11, Form 2)*	68178081	61430876	71520000		61866503	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1415829	1474580	1310179		1574580	
b. Infants < 1 year old	222486	156981	245944		291200	
c. Children 1 to 22 years old	4643076	2998128	4672955		3013732	
d. Children with	4919347	2139223	1503947		2339246	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	190743	376264	251775		362045	
g. SUBTOTAL	11391481	7145176	7984800		7580803	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	84600		84600		84600	
c. CISS	140000		132100		140000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	56433000		63197600		53940600	
h. AIDS	0		0		0	
i. CDC	129000		120900		120500	
j. Education	0		0		0	
k. Other						

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	5515862	2650299	2631796		2650298	
II. Enabling Services	3625457	1985223	3237698		2337438	
III. Population-Based Services	213140	56615	167060		140028	
IV. Infrastructure Building Services	2037022	2453039	1948246		2453039	
V. Federal-State Title V Block Grant Partnership Total	11391481	7145176	7984800		7580803	

A. Expenditures

Significant Year to Year Expenditure Variations:

In the fiscal year 2009, the expenditures for services for children and adolescents as well as children with special health care needs were higher than the required percentages, similar to other states. The amount expended toward services to children and adolescents represents approximately 43 percent of the total MCH federal budget. The amount allocated toward children with special health care needs represents 31 percent of the federal budget. Overall, the amount allocated toward children and adolescents, including the state funding equals 45 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 30 percent. The amount spent on mothers represents 22 percent of the entire budget. 20 percent of the total was spent on women out of the federal budget.

The State of New Mexico converted over to a new financial system known as SHARE. This system now tracks budgets via a Department code, fund codes and project ID's, depending on the funding source. We are just entering the second year of this system and have worked through

many of the issues that plagued the system upon its introduction. In past years the state match amount was considerably greater than the required three state dollars to four federal dollars. However, in this economic climate the Department of Health general fund allocation to the Title V Block Grant is at the required amount with very little state dollars to overmatch the federal dollars.

There is a significant variation in expenditures this year due to decreased state funds. Additional state matching funds previously appropriated towards Children with Special Healthcare Needs was reduced considerably, some programs were eliminated completely. Safety net services which include MCH services such as High Risk Prenatal Care Fund, Maternal Health, and Children with Special Health Care Needs continue to be funded however; many programs also pull in a minimal amount of revenues. It is evident through analysis of expenditures, that the grant continues to be spent more and more on direct services due to several factors. First, there is a great influx of undocumented immigrants coming to the State. Hospital costs continue to increase. The CSHCN Program has made a concerted effort to transition the highest cost patients to the New Mexico Medical Insurance Pool (NMMIP). The state has not offset the federal reduction in funding, thus direct services are depleting funds for some infrastructure and population based services. This year the State had to decrease the amount it is spending for contracting services out of our General Funds. This will significantly impact access to care for services. Costs are still escalating for serving children with special health care needs. The flat budget for the CMS Program over the last few years resulted in increased pressure from the hospitals to increase per diem rates for hospitalized children and youth. The Healthier Kids Fund Program funded by state appropriation has been eliminated due to budget shortfalls. The cost to serve children under this program was less than $300.00 per child per year. The Bureau continues to try to proactively address factors impacting birth outcomes such as obesity, preconception, prenatal care utilization, alcohol, substance abuse, tobacco, mental health, unintended pregnancy, and eliminating disparities between documented and undocumented pregnant women in access to services. While evidence-based interventions are increasingly requested, there are few resources to evaluate the impact of programs. A hiring freeze which went into affect approximately 9 months ago has impacted our MCH Epidemiology program; with vacancies and retirements, the program is functioning with only 43 percent staff.

The Family Planning Program continues to receive funding via Title X, Teen Outreach program (TOP) and Teen Pregnancy Prevention (TPP). The Male Involvement grant in Luna Co. has expired and the program will apply for another Male Involvement grant in another county.

The WIC Program expanded the EBT project statewide and continues to apply for additional funding through ARRA. The need for safety net programs has not diminished in the face of Medicaid budget deficits and increased immigration. The High Risk Prenatal Care fund which uses state funds to serve undocumented immigrants has far outstripped current resources. The Bureau is applying for state expansion funds in this area, but due to many budget challenges, the state may not prioritize this need.

For Children's Medical Services (CMS) Children and Youth with Special Health Care Needs Program (CYSHCN), Governor Richardson proposed an increase in multidisciplinary pediatric outreach clinics in outlying areas. Governor Richardson became aware that there were not enough clinics to meet the expressed need for pediatric specialty services for children in rural areas. He proposed a 1 million dollar expansion for CMS. The Legislature appropriated $500,000.00 for a combination of CMS issues. $100,000 was given for the deaf and hard of hearing community, $100,000 went to the blind and visually impaired community and $300,000 was given to CMS for orthopedic patients and will be used for addressing an unmet need for outpatient orthopedic services for existing CMS clients.

The need for services continues to increase in New Mexico, however in this economic climate the funding and resources continues to decline. Those at risk are held to receiving services and funding however, many other services have been reduced.

B. Budget

The Federal support received from the MCH Block grant complements the State's total efforts to optimize services to the MCH population. In the 2007 federal grant budget, the amounts allocated to services for children and adolescents as well as children with special health care needs were higher than the required percentages and slightly higher than FY2006. The amount allocated toward children with special health care needs represents 31 percent of the federal budget. The remaining amount allocated for women, represents 20 percent of the federal budget. 4% of the federal budget is expended on administration. Overall, the amount allocated toward Children and Adolescents, including the state funding equals 45 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 30 percent. The amount spent on mothers represents 22 percent of the entire budget. Resources previously spent for prenatal care media campaigns were shifted to the High Risk Prenatal Care Fund. In addition, other resources are being sought to fill this need. The year has been spent analyzing current budgets across Title V programs. A review of the final FY2009 budget as compared to the initial budget for SFY2006 (state year), With the initial low budgeting of the program by the Public Health Division and budget adjustments during the year to meet costs of safety net operations, seldom can the Title V Program operate within 10 percent of the original state year budget as required.

The State of New Mexico converted over to a new financial system known as SHARE. This system now tracks budgets via a Department code, fund codes and project ID's, depending on the funding source. We are just entering the second year of this system and have worked through many of the issues that plagued the system upon its introduction. In past years the state match amount was considerably greater than the required three state dollars to four federal dollars. However, in this economic climate the Department of Health general fund allocation to the Title V Block Grant is at the required amount with very little state dollars to overmatch the federal dollars.

The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal percent of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant. Because New Mexico has high rates of birth defects, low levels of early prenatal care and oral health care, Department of Health Secretary Alfredo Vigil included this as one of the priorities in the revised Strategic Plan. Preconception health care: Birth defects and low birth weight are both associated with short and long term expensive medical costs and reduced lifelong productivity. Within public health clinics clients receive very limited screening and education to promote healthy behaviors related to pre-pregnancy health risks of family Violence, Alcohol, Substance abuse and Tobacco (VAST). Prenatal care has been shown to prevent poor birth outcomes. Oral Health care before and during pregnancy is increasingly seen as a way to prevent premature birth and low birth weight. The other request that is in the top five is preventing teen pregnancy, suicide and gambling. Suicide, pregnancy and gambling are three major health issues among teens in New Mexico. Suicide among youth aged 15-24 is a major health crisis in New Mexico. In 2006, the national youth suicide rate was 64 per 100,000 while New Mexico's rate was 84 per 100,000. Nationally, suicide is the third leading cause of death for 15-25 year olds. In New Mexico it is the second leading cause of death.

The budget request in 2009 for allocations towards the MCH initiative did not pass, therefore the MCH initiative was left flat funded for the majority of 2009 with the exception of budget cuts beginning in November of 2009. Due to the economy any monies from our general fund that was not being paid out or encumbered was disencumbered back to the Department to cover existing expenses. Currently contracts have been cut by 18 percent. Vacant positions not currently 100 percent federally funded or positions not providing direct clinical services have been placed on a freeze.

The New Mexico Legislative Finance Committee (LFC) performed a cross agency audit of all

early childhood programs to determine efficiency and duplicative efforts for services. The LFC determined the DOH was performing in the best interests of early childhood as noted by the data provided by the Department. LFC recommended the DOH consider implementing a pilot project of the Family Nurse Partnership and requesting legislative financing for such and endeavor. This would assist with many of the early childhood indicators.

Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured. The administrative component, paid totally out of state funds is comprised of the Family Health Bureau Chief's budget and includes fiscal, program, and personnel management, systems maintenance, strategic planning, and advocacy.

The budget meets the target percentages for Preventive and Primary Care for Children, Children with Special Health Care Needs, and Administration.

The Department of Health's accounting system contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail.

The block grant award received in 2009 decreased by approximately $88,000. Program budgets were adjusted for the cut accordingly. Services were affected either by the cut to services, the number of people served or the number of staff available to provide the services

The summary budgets are an aggregation of all of the Project Identification Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Project Identification Codes are program specific: e.g., Maternal Health, Title V, Adolescent Pregnancy Prevention/Family Planning, Child Health, Adolescent Health/Youth Development, Children's Medical Services, etc. Each Project I.D. is allocated funding showing the federal/state distribution. The state match amount is the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of $3,087,900.

The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal percent of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant.

Due to the economic status budget allocations decreased this year for services not associated to the federal match to the Block Grant.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.